Manitoba's Comparable Health Indicator Report

A Federal/Provincial/Territorial Agreement on Comparable Indicator Reporting reached by First Ministers and developed by the Conference of Deputy Ministers

November 2004

Manitoba
Building for the Future

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Executive Summary

Building on the September 2000 First Ministers' Meeting Communiqué on Health, the February 2003 First Ministers' Accord on Health Care Renewal directed Health Ministers to develop additional indicators to supplement the work undertaken in response to the September 2000 Communiqué. With input from a range of stakeholders and experts, consultation with other federal/provincial/territorial (FPT) groups and the general public, all 14 jurisdictions agreed to report on 70 indicators (81 sub-indicators). Eighteen indicators (21 sub-indicators) were required to be featured in the 2004 reports, while the remaining 52 indicators (60 sub-indicators) were to be made available on a common website. Jurisdictions could choose to include these in their reports.

In this report, Manitoba has chosen to report 40 indicators (45 sub-indicators) to highlight key areas of particular interest to Manitobans. These fall into three general categories:

- Healthy Living
    - self-reported health
    - life expectancy
    - infant mortality
    - low birth weight
    - chronic diseases
    - health promotion and disease prevention
- Access to Health Care Services
    - health information or advice
    - primary health care
    - family doctor
    - immediate care
    - routine care
    - ambulatory care sensitive conditions
    - wait times for elective diagnostic services
    - prescription drug expenditures
- Patient Satisfaction and Quality of Care Received
    - telehealth services
    - community-based care
    - physician care
    - hospital care

For most indicators, comparisons to Canada were made. The Auditor General of Manitoba has provided an independent verification of all indicators discussed in this report.

Healthy Living

Healthy living is about creating conditions and adopting behaviours that promote good health. Manitoba has endorsed and is participating in the development of the national Integrated Pan-Canadian Healthy Living Strategy and its two goals; 1) to improve the overall health of Canadians, and 2) to reduce health disparities among Canadians. In this report, outcomes of healthy living are measured by self-reported health, life expectancy, infant mortality, low birth weight, mortality rates for cardiovascular disease, incidence rates for cancer, prevalence of diabetes, mental health, sexually transmitted infections, unintentional injuries, improving our health, and other indicators related to the goals of healthy living.

In 2003, the Canadian Community Health Survey (CCHS) asked people to rate their own health as excellent, very good, good, fair or poor. **Self-reported health** is considered a good measure as it is known to correlate strongly to actual health. About 62 per cent of Manitobans rated their health as "very good" or "excellent," compared to 60 per cent for all Canadians. About 10 per cent of Manitobans and Canadians surveyed rated their health "fair" or "poor."

Life expectancy measures how long people might expect to live. It represents the average age at which a group of people, of the same age and gender, are likely to die. Between 1979 and 2001, life expectancy at birth, for both Manitobans and Canadians, has risen three to four years. Women have a longer life expectancy than men; however, men are beginning to "narrow the gap." In 2001, the life expectancy at birth of Manitoba females was 81.6 years, compared to 75.7 years for Manitoba males. Nationally, life expectancy for females was 82.1 years; for males, 77.0 years.

Health Adjusted Life Expectancy (HALE) is an estimate of the number of years that an individual can expect to live in "full health." In 2001, HALE for Manitoba females was 70.4 years, compared to 66.7 years for Manitoba males. HALE was 70.8 years for Canadian females and 68.3 years for Canadian males.

One of the most widely used indicators for international comparisons of a population's health status is the **infant mortality** rate. This indicator identifies the number of infants who die within the first year of life per 1,000 live births. In 2001, Manitoba's infant mortality rate was higher than the Canadian rate, although the overall trend since 1979 has been improving. Also, the infant mortality rate was higher for males than females, for both Manitoba and Canada.

Low birth weight is another key indicator of the general health of newborn babies. Low birth weight is represented as the proportion of live births with a birth weight less than 2,500 grams but no less than 500 grams. In 2001, 5.4 per cent of all live births in Manitoba had low birth weights. This is similar to the Canadian average of 5.5 per cent.

Chronic diseases are a major and growing burden in our population. This report looks at the most common chronic diseases, including cardiovascular disease, diabetes, cancer and mental illness, and compares Manitoba's rates to Canada as a whole. For example, the age-standardized mortality rate for heart attacks is 48 deaths per 100,000 for Manitoba, compared to 52 deaths per 100,000 for Canada in 2001. These numbers have declined dramatically since 1979. Like heart attack deaths, deaths due to stroke have also declined since 1979. In 2001, Manitoba's age-standardized mortality rate for stroke was 37 deaths per 100,000, compared to the Canadian rate of 34 per 100,000.

The type of cancer causing the most deaths in Canada is lung cancer. In 2000, about 60 new cases of lung cancer per 100,000 population were diagnosed in Manitoba, compared to 58 new cases per 100,000 population for Canada as a whole. In 2001, the age-standardized mortality rate for lung cancer in Manitoba was 45 deaths per 100,000, with a higher rate for males than females.

Breast cancer is the most common cancer affecting Canadian women. Since 1979, the mortality rate for breast cancer has declined. Another leading cause of cancer deaths is colorectal cancer. In 2001, the age-standardized mortality rate for colorectal cancer in Manitoba was 18 deaths per 100,000, with the rate for males almost twice as high as that for females.

Another common chronic disease is diabetes. In 1999-2000, the age-standardized percentage of people living with diabetes in Manitoba was 5.5. The comparable Canadian value is 4.8 per cent.

Mental health is fundamental to an individual's overall health and the health of communities. In 2000, the CCHS showed that seven per cent of Manitobans likely suffered from depression, with significantly more women affected than men. The most extreme outcome of depression is suicide. Potential years of life lost (PYLL) is the number of years of life lost when a person dies prematurely before the age of 75. In 2001, The PYLL due to suicide was 375 years per 100,000 population in Manitoba. The rate for males was more than double that for females.

The report also looks at the incidence of chlamydia. In 2002, the Manitoba incidence rate for chlamydia was 289 cases per 100,000. This rate was higher than the Canadian rate of 179 per 100,000. Over the last few years, chlamydia incidence rates in Manitoba and Canada have been increasing.

Several main areas of **health promotion and disease prevention** are highlighted in this report. These include obesity, physical activity, smoking, PAP testing, mammography and immunization for those aged 65 years or older. Data for this section is from information gathered in the CCHS.

In 2003, 42 per cent of Manitobans surveyed had an ideal or normal weight, compared to 48 per cent nationally. Eighteen per cent of Manitobans reported being obese, compared to 15 per cent nationally. In 2003, less than 30 per cent of Manitobans surveyed reported being physically active; about 47 per cent reported being inactive. These numbers are similar to the Canadian rates.

In the same survey, 14 per cent of Manitoba teens reported that they smoke, comparable to the national rate of 15 per cent.

Screening and preventative measures, such as vaccinations, also play an important role in keeping people healthy. The CCHS reported that in 2003, 78 per cent of Manitoban women aged 18 to 69 years had a PAP test within the last three years. The comparable Canadian value was 75 per cent. About 72 per cent of Manitoba women 50 to 69 years of age had at least one mammogram in the two years prior to 2003. The survey also reported the percentage of individuals aged 65 years and older who received an influenza immunization (flu shot) within the last year. In 2003, 56 per cent of Manitobans and 62 per cent of Canadians in this age group reported having been immunized.

Access to Health Care Services

In this report, access to health care services is examined across a number of categories, including access to health information or advice, access to primary health care, wait times for diagnostic services and drug expenditures.

In the 2003 Health Services Access Survey (HSAS), 82 per cent of Manitobans accessing **health information or advice** reported no difficulty, compared to 84 per cent nationally. The same survey reported that 75 per cent of Manitobans accessing **immediate care** reported no difficulty, compared to 76 per cent nationally. Finally, 81 per cent of Manitobans accessing **routine care** reported no difficulty, compared to 84 per cent for all Canadians.

Conditions that may be cared for in the community, rather than in hospital, are called **ambulatory care sensitive conditions**. High rates of hospital admissions for these types of conditions may indicate that there are problems with patients getting the care they need at a community level. Over time, the Manitoba rate for ambulatory care sensitive conditions appears to be consistently higher than the Canadian rate. In 2001-02, the Manitoba age-standardized hospitalization rate for such conditions was 440 admissions per 100,000, compared to 346 admissions per 100,000 for Canada in total.

The report also looks at **wait times for elective diagnostic services** such as an MRI, CT scan or angiography. In 2003, about 48 per cent of Manitobans surveyed who had a diagnostic procedure waited less than one month for the procedure, compared to 58 per cent nationally. The median wait time for an elective diagnostic procedure was four weeks for Manitoba, compared to two weeks for Canada, but this difference is not statistically significant.

A final indicator of access to health care is the proportion of households who spend a significant portion of their income on **prescription drugs**. A 2002 Statistics Canada survey reported that the proportion of Canadian and Manitoban households that spend more than five per cent of their after-tax income was similar at about three to four per cent.

Patient Satisfaction and Quality of Care Received

The third main category that this report looks at is patient satisfaction and perceived quality of care received. The 2003 CCHS and HSAS both included questions on perceived quality of different types of health care services, both community-based and in hospital, and patients' satisfaction with these different types of care.

In 2003, an estimated 95 per cent of Manitobans surveyed reported receiving some kind of health care service in the preceding 12 months. About 83 per cent of those Manitobans indicated that they were very or somewhat satisfied with the way health care services were provided, compared to 85 per cent nationally. An estimated 85 per cent of Manitobans rated the quality of care they received to be "excellent" or "good."

These surveys also reported on satisfaction and quality for specific kinds of health services. These included **telehealth services, community-based care, physician care** and **hospital care**. For example, 63 per cent of Manitobans reported that they had received some kind of care from a physician in the preceding 12 months. About 91 per cent of those Manitobans indicated they were very or somewhat satisfied with the way those health care services were provided. An estimated 92 per cent of the same Manitobans rated the quality of care they received as "excellent" or "good."

Conclusion

It is hoped that Manitobans will use the information in this report in a variety of ways to become healthier and reduce health inequalities within our population. In the simplest analysis, these data can be used as indicators of prevention, disease rates and the quality of health care provided to Manitobans. Data, such as those in this report, are a useful reference for this ongoing work by indicating our current status and what more can be achieved. In most cases, the information presented should stimulate further discussion and research. The main goal of this report will be achieved if the indicators presented can be interpreted to show us where action is needed now, and in the future, to improve the overall health of Manitobans while reducing health disparities within our population.

Background

The September 2000 *First Ministers' Meeting Communiqué on Health* directed Canada's Health Ministers to collaborate on the development of a comprehensive framework to report on health status, health outcomes and quality of service using jointly agreed-upon comparable indicators. This was intended to serve several objectives by providing information to Canadians on government performance, as well as assisting individuals, governments and health care providers to make more informed health choices.

In September 2002, all 14 jurisdictions, including the federal government, released comparable indicator reports on a set of 67 indicators. This marked the first time that health ministries from all Canadian jurisdictions concurrently reported to their constituents.

The February 2003 *First Ministers' Accord on Health Care Renewal* directed Health Ministers to develop more indicators to supplement work undertaken in response to the September 2000 Communiqué. This work was to be completed by September 2003. Before the completion date, experts and stakeholders were asked to review this work to ensure these new indicators:

- measured progress on achieving the reforms set out in the Accord; and
- met the objectives of timely access, quality, sustainability, health status and wellness.

The 2003 Health Accord identified the following priority areas for reform:

- healthy Canadians,
- primary health care,
- home care,
- catastrophic drug coverage and pharmaceutical management,
- diagnostic and medical equipment, and
- health human resources.

Federal/provincial/territorial jurisdictions agreed on 70 indicators (with 81 sub-indicators), based on requirements set out in the 2000 Communiqué and the 2003 Health Accord; input from a range of stakeholders and experts; consultation with other federal, provincial and territorial groups and the general public. Stakeholder consultations were conducted at an invitational workshop in June 2003. Further stakeholder input was solicited through written submissions. In addition, a website was created to garner public feedback. Focus group testing to obtain public feedback was undertaken in January 2004, to get opinions from Canadians about the kinds of indicators they view as important and meaningful. These focus groups were held in four Canadian cities, including Winnipeg.

This report contains information on a subset of indicators from the 2004 reporting cycle that describe two areas of particular interest to Manitobans: healthy living and citizen access to, and satisfaction with, health care. Manitoba data on the entire set of indicators from the 2004 reporting cycle is available on the Manitoba Health website **www.gov.mb.ca/health/index.html** (or **www.gov.mb.ca/health/index.fr.html**). This same information, along with comparable information for all the provinces, territories and the federal government, is available at **www.cihi.ca/comparable-indicators** (or **www.icis.ca/indicateurs-comparables**).

Introduction

Indicators directly describe a specific measurement (ex: the percentage of Manitobans who report being physically active). They also "indicate" something more, such as degree of progress towards meeting a goal. With health indicators, this might include improvements in health status, disease prevention or treatment. The measurement itself is generally straightforward, based on definition and mathematics. The meaning of that measurement (a single "indicator" or set of indicators) is open to interpretation.

The meaning of the indicators in this report will vary with the observer, depending on point of view, values and other considerations. Indicators can be interpreted according to their absolute value (ex: "Only 42 per cent of Manitobans have healthy weights and that is too few") or their relative value (ex: "Fewer Manitobans have healthy weights than Canadians overall"). If comparable data from other years are available, such measurements can also show progress or trends. A good indicator should always have a directional aspect; in other words, we should know in advance whether a higher or lower value for an indicator is "good" or "bad" (ex: A higher proportion of Manitobans with healthy weights is good, a lower proportion is bad). Beyond that, there is no right or wrong way to interpret one or more indicators.

The indicators in this report are described as "comparable," because each jurisdiction has used the same definitions and calculations to produce data. However, the reader should exercise caution in drawing conclusions, since limited information can be obtained from a simple statistic. For example, only a few indicators are further described by extra dimensions such as income (ex: life expectancy).

Other factors to consider are the subjectivity of some data (ex: survey questions) and the fact that many things may contribute to the measurement of a single indicator. The mortality rate of any condition (ex: heart attack) reflects a whole spectrum of prevention and care, including living conditions, lifestyles, availability and use of diagnostic methods, quality of care from health care providers and family, and adherence to treatment regimens.

Data sources and notes

Survey data

Much of the information in this report is from national surveys such as the National Population Health Survey (NPHS), the Canadian Community Health Survey (CCHS) and the Health Services Access Survey (HSAS). The source for each indicator, including the year of the survey, is noted as a footnote to the corresponding figure.

Statistics Canada conducts these surveys. The number of people interviewed in each province and territory is such that the information, for the most part, can be reliably extrapolated to represent a particular province or territory. Occasionally, survey results for a particular question may be unreliable, usually because the final number of responses for a particular question was small. Where that is the case, this is noted in the figure. Such values should be interpreted with caution.

Although national surveys such as the CCHS, HSAS and the NPHS are designed to be representative of the general population, they are not completely representative. Certain groups are not included in these surveys, such as people living on First Nations reserves and Crown lands, residents of institutions (such as personal care homes), full-time members of the Canadian Armed Forces and residents of some remote regions. This may have important implications for data interpretation, as individuals in these groups may perceive their health and health experiences very differently from the general population.

Data standardization

Information in this report is often presented as a proportion or as an age-standardized rate. Unless otherwise noted, rates are standardized to the 1991 Canadian population. Age-standardization adjusts for differences in the age distribution between groups, permitting comparisons across different groups or over time. Since the goal of these reports is to report comparable indicators, the use of standardized data is critical. One limitation of standardized data is that it usually does not represent the actual number of people with a particular disorder: this information is reflected in the "crude" rate only. Crude rates for some indicators are available at **www.cihi.ca/comparable-indicators (www.icis.ca/indicateurs-comparables)**.

Indicator definitions

The definitions, technical specifications and requirements for data presentation developed during the national planning process have been followed in this report. The detailed technical specifications on which the indicators are based are available electronically at **www.cihi.ca/comparable-indicators (www.icis.ca/indicateurs-comparables)**

The Office of the Auditor General of Manitoba conducted an independent verification of the indicators produced in Manitoba and featured in this report. Indicators based on data from national sources were verified through the office of the Auditor General of Canada.

Statistically significant differences

Significance testing was not performed for population-based indicators such as life expectancy, potential years of life lost or standardized mortality rates. This is because such indicators are based on the entire population. Significance testing was performed for most survey-based indicators (in other words, those based on a sample of the entire population), to determine if differences in reported values were statistically different or if there was essentially no difference.

Statistical testing was performed for the following differences:

- Manitoba values compared to those for Canada;
- gender differences where gender-specific information has been provided; and
- the difference between values reported for the first year and the most current year, where time trends have been presented.

It is noted within the text or in the figure footnotes whether the differences reported are statistically different.

Not all statistically significant differences will necessarily have practical significance. When large numbers of observations are compared, sometimes even very small differences may be statistically significant. It is up to the reader to determine how important such differences might be. For example, if twice as many women as men die of a particular disease, and this difference is statistically significant, this might be viewed to be of greater concern than a statistically significant difference of one percentage point between Manitobans and Canadians in rating their health as "very good" or "excellent."

Conversely, even apparently large differences may not be significant if they are based on relatively few observations. For example, Manitoba rates for some indicators may be more variable than the national rate because the Manitoba rate is based on only a small number of observations. This is important to remember both when comparing Manitoba and Canadian rates, and when comparing Manitoba rates over time.

Manitoba

Deputy Minister
of Health
of Healthy Living

Winnipeg, Manitoba R3C 0V8
CANADA

Management's Responsibility for Health Indicator Reporting

The Minister of Health is responsible for the integrity of Manitoba's Comparable Health Indicator Report. My responsibility was to oversee the preparation of this report.

Manitoba Health is reporting on 66 out of a total of 70 indicators that were identified through a provincial/territorial and federal government planning and consultation process. Forty of these indicators are being featured in this report. To the extent possible given available data, the indicators that are reported are defined as agreed to during the national planning process, and the technical requirements for calculating the indicators have been adhered to. Information is provided where departures from agreed upon specifications were necessary, or if further explanation was required to assist in data interpretation.

The information in Manitoba's Comparable Health Indicator Report and the health information systems of Manitoba Health is the responsibility of this department. This responsibility consists of maintaining the required information systems and adequate controls to ensure that the information generated by the systems is accurate and that the performance indicators and related explanations found in the report are reliable.

In the preparation of the Report, Manitoba Health also relied on information provided from external parties, including Statistics Canada, Canadian Institute for Health Information (CIHI), and Health Canada. The Department is reasonably confident that the information obtained from external sources is free of significant misrepresentation.

Limitations in data systems maintained by Manitoba Health are described in the Report. It should be noted that the completeness and accuracy of source data (such as diagnoses by health professionals and original reporting of such information in health records) has not been verified in the process of preparing this Report. We are unable to determine whether any adjustments to reported Manitoba health indicators, due to these limitations might be necessary.

To the best of our knowledge the information in the report is reliable unless otherwise noted and explained, and the reported indicators fairly reflect the facts to a reasonable level of accuracy.

The Auditor General of Manitoba was engaged to provide third party verification in the form of an audit opinion on the Report.

Milton Sussman

November 30, 2004

Milton Sussman

Office of the Auditor General

500 - 330 Portage Avenue
Winnipeg, Manitoba
CANADA R3C 0C4

AUDITOR'S REPORT

To the Minister of Hea'th

I have audited the 40 Manitoba health indicators presented in Manitoba's Comparable Health Indicator Report dated November 2004, as prepared by the Manitoba Department of Health pursuant to the First Ministers' Accord on Health Care Renewal of February 2003. The Conference of Deputy Ministers of Health defined 18 required indicators and 52 optional indicators to be reported to Canadians. The Department of Health is responsible for reporting Manitoba health indicators in accordance with Criteria in Annex 1, and has reported 18 required and 22 optional indicators. My responsibility is to express an opinion on the 40 health indicators based on my audit. However, my responsibility does not extend to assessing the performance achieved by the Manitoba Department of Health, nor the relevance or sufficiency of the Manitoba health indicators selected for reporting. My audit was limited to information of the most recent year for each Manitoba health indicator reported.

Data for Manitoba's Comparable Health Indicator Report are derived from four main sources:

- Manitoba Department of Health, Provincial Health Information Systems;
- Statistics Canada;
- Canadian Institute for Health Information (CIHI); and
- Health Canada.

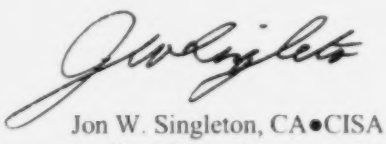
I conducted my audit in accordance with standards for assurance engagements of the Canadian Institute of Chartered Accountants. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the Manitoba health indicators presented are free of significant misstatement. To this end, I have audited these health indicators to determine whether they meet the Criteria in Annex 1 of my report. Such an audit includes examining, on a test basis, evidence supporting the Manitoba health indicators and disclosures. An audit also includes assessing significant judgments made in the Manitoba Comparable Health Indicator Report by management of the Manitoba Department of Health.

Management of the Manitoba Department of Health has adequately disclosed the limitations of source data with respect to completeness and accuracy in their Statement of Management Responsibility, which precedes this audit opinion, and in the Data sources and notes section, and throughout Manitoba's Comparable Health Indicator Report.

In my opinion, ***except for the effect of any adjustments if any, which I might have determined to be necessary had the source data limitations as noted above not been present,*** the 40 Manitoba health indicators included in Manitoba's Comparable Health Indicator Report dated November 2004, are in all significant respects, presented fairly in accordance with the Criteria in Annex 1, and provide the information required by the public reporting commitment made in the First Ministers' Accord on Health Care Renewal of February 2003. I have not examined and do not express an opinion on the results of indicators presented for prior periods.

Manitoba's Comparative Health Indicator Report includes comparison to consolidated national health indicators not audited by me. Consolidated national health indicators were compiled from indicator data of other provinces, territories and federal government programs. This data has been audited by other auditors, or other auditors have been engaged to perform specified auditing procedures. Annex 2 includes an explanation of the difference between these two types of engagements and identifies the nature of the engagement performed in each of the jurisdictions. The auditors' findings and observations resulting from engagements in other Canadian jurisdictions are included in the reports of the respective jurisdictions.

I am encouraged by the work undertaken by the Manitoba Department of Health in the preparation of its second health indicator report. Reporting on health indicators is a continuing work in progress. Readers are encouraged to use Manitoba's Comparative Health Indicator Report, but in doing so, to keep in mind the impact of source data limitations.



Winnipeg, Manitoba
November 23, 2004

Jon W. Singleton, CA•CISA
Auditor General

ANNEX 1

Audit criteria

The Manitoba Department of Health has acknowledged the suitability of the following criteria:

Completeness

According to the 2003 First Ministers' Accord on Health Care Renewal, the Conference of Deputy Ministers approved 70 indicators, including a subset of 18 indicators that all jurisdictions are to feature in their 2004 reports. All health indicators reported comply with the definitions, technical specifications and standards of presentation as approved. The 18 required health indicators were reported.

Accuracy

The health indicators reported adequately reflect the facts, to an appropriate level of accuracy that includes the ability to make comparisons between jurisdictions and between the 2002 and 2004 reports, where applicable.

Adequate Disclosure

The health indicators are defined, and their significance and limitations on the data are explained. The report states and properly describes departures from what was approved by the Conference of Deputy Ministers, and explains plans for the future resolution of departures.

ANNEX 2

Verification of Comparative Information from Other Jurisdictions

The governments of Canada, the Territories and the Provinces have adopted different approaches to meet the February 2003 First Ministers Accord on Health Care Renewal requirement in respect of third party verification for their health reports. Some have engaged their auditor to provide audit assurance on their health reports and others have asked for specified auditing procedures to be applied. The paragraphs below outline the major differences between an audit assurance engagement and a specified auditing procedures engagement. For a complete comparison, please refer to the CICA Handbook section 5025 for audit assurance engagements and section 9100 for specified auditing procedure engagements.

In an attest audit engagement, the auditor's responsibility is to offer assurance to users, in the form of an audit opinion, on a report prepared by management. The auditor determines the nature, extent, timing, appropriateness and sufficiency of audit procedures, which, in the auditor's judgment, are necessary to provide a high level of assurance concerning the subject matter, or the health indicators in a health indicators report in the present context.

In a specified auditing procedure engagement, the auditor's responsibility is to report the results of applying auditing procedures specified by management. As the extent of specified auditing procedures may vary from engagement to engagement, such engagements are difficult to compare. And since the extent of the procedures performed is not sufficient to constitute an audit, the reports do not provide an audit opinion. Reports state those procedures actually applied and only the factual results of those procedures, leaving the reader to determine the fairness of the information.

The following is a list of jurisdictions that have engaged their auditor to provide audit assurance on their health indicators, and those that have asked for specified auditing procedures to be applied.

Audit opinion **CICA 5025**	**Specified Auditing Procedures** **CICA 9100**
British Columbia	Alberta
Saskatchewan	Ontario
Manitoba	New Brunswick
Quebec	Prince Edward Island
Nova Scotia	Newfoundland and Labrador
Yukon	
Northwest Territories	
Nunavut	
Canada	

Healthy Living

Many factors other than access to medical professionals and hospitals affect the health of Manitobans. These include things like family history and gender, as well as other determinants of health such as culture, education, employment, income, the environment, our personal health practices and social support networks.

Healthy living is about creating conditions and adopting behaviors that promote good health. By making healthier choices and working together to create environments that support health, individuals can reduce their risk of illness and injury. Healthier choices include personal decisions to eat healthy foods, be physically active and to avoid harmful substances or activities. Healthy living also includes living in supportive environments such as safe, healthy homes; having meaningful employment and healthy working conditions; smoke-free public spaces; and access to nutritious and safe foods. Manitoba's Healthy Living website promotes and provides information about wellness, health education, and disease and injury prevention. For more information, visit: **www.gov.mb.ca/healthyliving/index.html** or **www.gov.mb.ca/healthyliving/index.fr.html.**

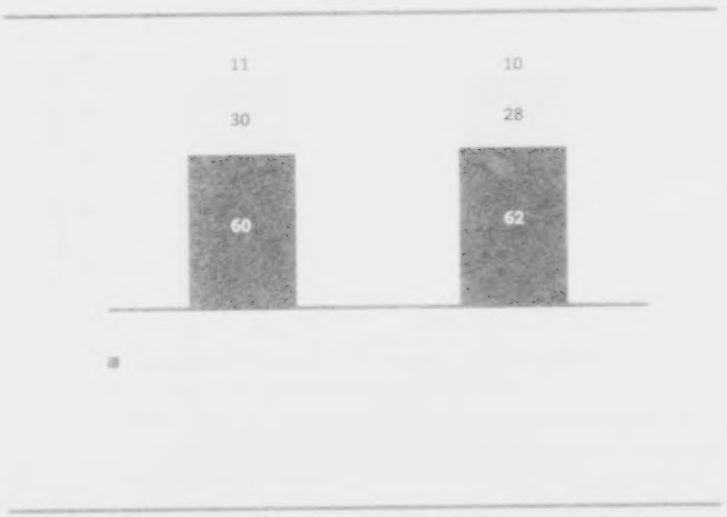
In 2003, the Manitoba Government announced the creation of a Minister of Healthy Living in recognition of the substantial impact that modifiable factors such as smoking, diet and exercise have on health.

How healthy do we think we are?

National survey data provides a look at how Canadians and Manitobans rate their own health. A "self-reported health" question, included in the Canadian Community Health Survey, asks respondents how healthy they think they are. It provides particularly valuable information, as it captures information that is otherwise difficult to obtain about an individual's psychological reserves and resilience. Self-reported health status is also known to correlate strongly with actual health as measured by other means.

Self-reported health status

As part of the Canadian Community Health Survey, respondents were asked to rate their health as "excellent," "very good," "good," "fair" or "poor." As Figure 1 shows, slightly (though significantly) fewer Manitobans than Canadians rated their health as "good" (28 and 30 per cent respectively) in 2003, but more of the Manitobans surveyed rated their health as "very good" or "excellent." This value was slightly (and significantly) higher than the comparable value for Canada (62 per cent vs. 60 per cent). About 10 per cent of those Manitobans and Canadians surveyed said that their health was fair or poor.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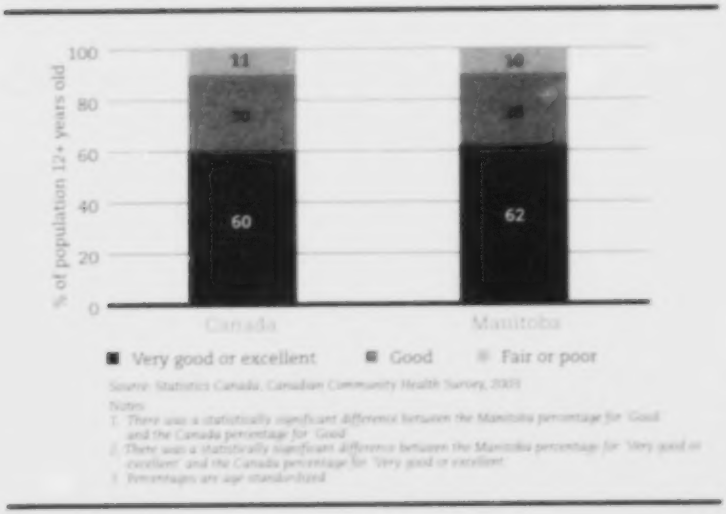


Source: Statistics Canada, Canadian Community Health Survey, 2003

Notes:
1. There was a statistically significant difference between the Manitoba percentage for 'Good' and the Canada percentage for 'Good'.
2. There was a statistically significant difference between the Manitoba percentage for 'Very good or excellent' and the Canada percentage for 'Very good or excellent'.
3. Percentages are age standardized.

Figure 1. Self-Reported Health, Manitoba and Canada, 2003.

How healthy are we?

Three measures commonly used to assess the overall health of a population are:
- life expectancy,
- infant mortality, and
- low birth weight babies as a proportion of total births.

Life expectancy represents the average age at which a group of people born at the same time are likely to die.

Life expectancy reflects how long people might expect to live. Life expectancy is generally high in industrialized nations. Infant mortality (the number of babies that die during the first year of life) and low birth weight are both associated with poor maternal health, lifestyle and economic circumstances.

Life expectancy

Life expectancy represents the average age at which a group of people born at the same time are likely to die. Life expectancy can be expressed in a variety of ways, at different ages (life expectancy will change depending on the age at which it is calculated, reflecting the effects of the many different factors that influence mortality rates) and by gender. Such measures capture the "quantity" of life, but not its quality.

Life expectancy can also be presented under different conditions, such as health adjusted or disability-free life expectancy. The latter approaches attempt to capture information about the quality of life.

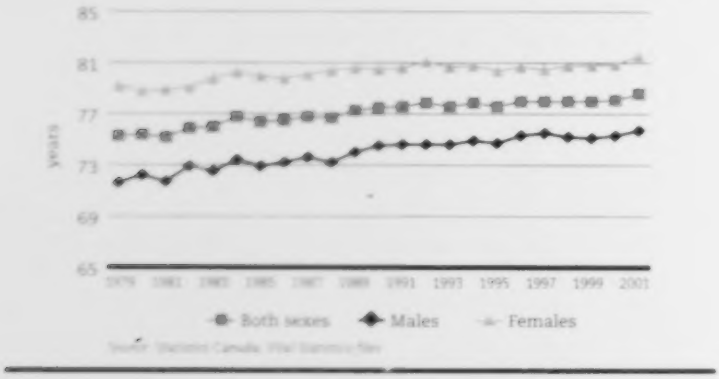
Life expectancy at birth

Life expectancy at birth is technically defined as an estimate of the number of years someone would expect to live if the age-specific mortality rates experienced in the year of their birth were to remain constant.

Historically, Canadian mortality rates have been falling, resulting in increased life expectancy. Since 1979, life expectancy at birth – both for Manitoba and Canada – has risen by between three and four years. Women, both provincially and nationally, have a longer life expectancy than men, a pattern characteristic of all developed countries.

Figure 2a shows the longer life expectancy of Manitoba women and how, although life expectancy overall continues to increase, men are beginning to "narrow the gap." For babies born in 1979, the life expectancy for females was, on average, seven and one-half years longer than for males. In 2001, the difference in life expectancy between the genders was only about six years. A female child born in Manitoba in 2001 can expect to live an average of 81.6 years and a male child, an average of 75.7 years. These values are lower than the corresponding national values of 82.1 years for women and 77.0 years for men.

Figure 2a. Life Expectancy at Birth, by Sex, Manitoba, 1979-2001.



Health adjusted life expectancy at birth

One measure that attempts to convey information about the anticipated quality of life, as well as its length, is health adjusted life expectancy (HALE). HALE is an indicator of overall population health that combines life expectancy with health status to estimate the average number of years that a person can expect to live in full health. HALE is calculated using age- and gender-specific morbidity (sickness) and mortality rates. As with life expectancy, HALE can be calculated in a number of different ways.

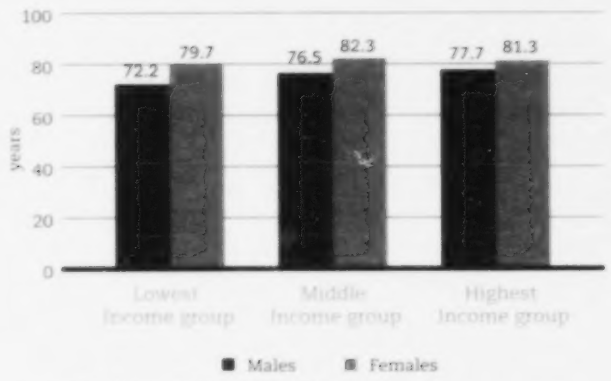
HALE is a relatively new indicator. It embodies a number of assumptions that are important for its interpretation. See the glossary for a definition of HALE.

If we look at HALE for Manitobans born in 2001, on average, females are expected to live 70.4 of their anticipated 81.6 years in full health; males, 66.7 of their anticipated 75.7 years. HALE for Manitoba women did not differ from the national value (70.8 years), but HALE for Manitoba men was lower than the corresponding value of 68.3 years for Canadian men.

Life expectancy at birth by income

Another way of looking at life expectancy is by income. Individuals from higher income groups tend to live longer than those from lower income groups.

Figure 2b shows life expectancy at birth based on income, for Manitoba. Income groups are inferred from the average household income of the area where the family (into which the baby was born) lived. When we look at life expectancy in this way we see that, for men, there is an increase in life expectancy across the three income groups. This same trend is seen for Canadian women, but not for Manitoba women, where the highest HALE is for the middle income group (82.3 years vs. 81.3 for the highest income group). Within the income groups, we still see that women live longer than men (Figure 2b). With the noted exception, the same patterns observed for Manitoba are seen nationally. However, the Canadian values for HALE are higher than those for Manitoba.



Source: Statistics Canada, Vital Statistics files

Figure 2b. Life Expectancy at Birth by Income Group and Sex, Manitoba, 2001.

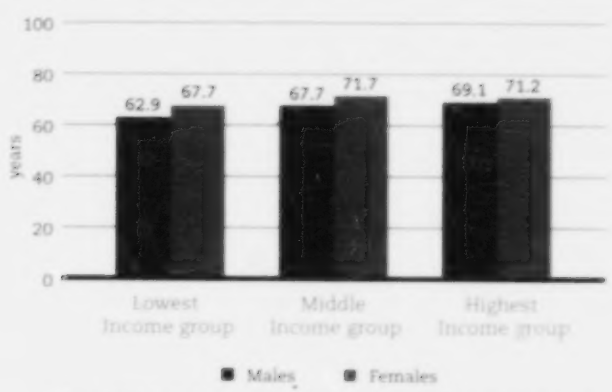
Health adjusted life expectancy at birth by income

If we look at HALE by income group (Figure 2c), we see that not only do Manitobans in the highest income group tend to live longer, but that they also anticipate more years of full health.

For Manitobans born in 2001, females in the lowest income group are expected to live 67.7 of their anticipated 79.7 years in full health, while females in the highest income group are expected to live 71.2 of their anticipated 81.3 years in full health.

Manitoba men in the lowest income group are expected to live 62.9 of their anticipated 72.2 years in full health; those in the highest income group, 69.1 of their anticipated 77.7 years.

Figure 2c. Health Adjusted Life Expectancy At Birth by Income Group and Sex, Manitoba, 2001.



Source: 2001 Census for counts of persons in long-term health care institutions (to match with sampling frame of the NPHS), CCHS Cycle 1.1 (common content) for HEU and counts of persons in households; 2000-2001 abridged life tables.

Infant mortality

The infant mortality rate is one of the most widely used indicators for international comparison of a population's health status. It is an indicator of the health of newborns and pregnant women alike. Infant mortality rates reflect both medical and social factors, such as income, demographic make-up, availability and access to health services, maternal education and smoking.

Figure 3a shows the infant mortality rate for Manitoba and Canada, and separately by sex, for 2001[1]. The infant mortality rate is higher for Manitoba infants compared to the Canadian average. Both nationally and provincially, the mortality rate is higher for male than for female infants. This is consistent with trends reported in industrialized countries worldwide.

Babies born with very low birth weights are usually extremely premature and tend to have high mortality rates, so they are generally excluded from infant mortality rates.

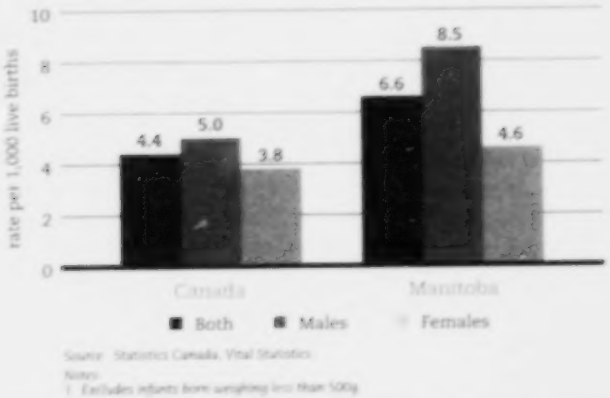


Figure 3a. Infant Mortality, by Sex, Manitoba and Canada, 2001.

Figure 3b offers a historical look at infant mortality in Manitoba and Canada. The Canadian numbers show a steady decline over time, from 10.5 deaths per 1,000 live births in 1979 to 4.4 in 2001. The Manitoba rate declined until the 1990s (from 11.7 deaths per 1,000 live births in 1979), but has levelled off at around six deaths per 1,000 live births.

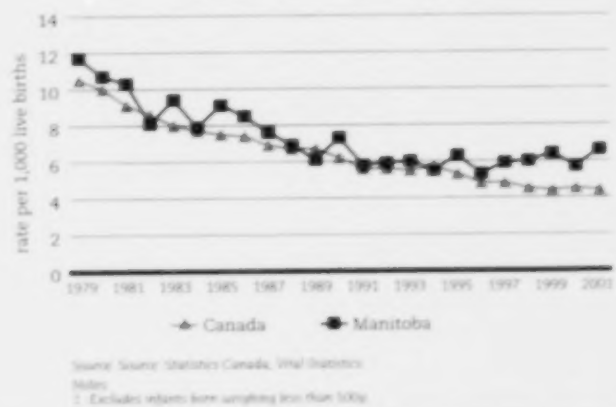


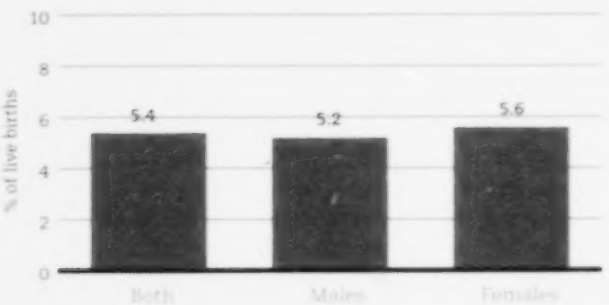
Figure 3b. Infant Mortality, Manitoba and Canada, 1979 - 2001.

Low birth weight

Low birth weight is an important indicator of the general health of newborns and is a key predictor of infant survival, health and development. Low birth weight babies are at an increased risk of dying during the first year of life and also have a greater risk of health problems, disabilities such as cerebral palsy and learning problems. Low birth weight is associated with prematurity, multiple births, and poor maternal health and economic circumstances.

Low birth weight is represented as the proportion of live births with a birth weight less than 2,500 grams but weighing at least 500 grams. Figure 4a shows the low birth weight rates for Manitoba. In Manitoba in 2001, 5.4 per cent of all live births had a low birth weight, 5.2 per cent of male live births and 5.6 per cent of female live births.

Figure 4a. Low Birth Weight by Sex, Manitoba, 2001.

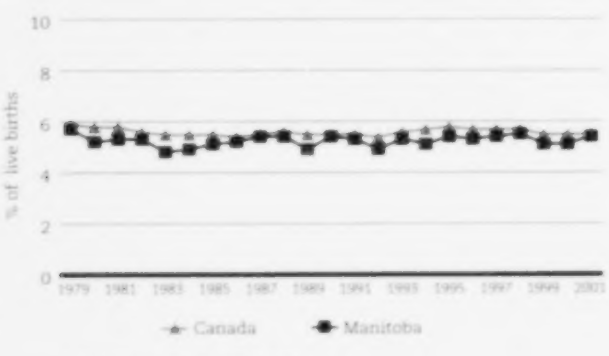


Source: Statistics Canada, Vital Statistics

Notes:
1. Only includes infants weighing less than 2,500 g but more than 500 g

Figure 4b shows the proportion of low birth weight babies over time. The number of low birth weight babies seems to be stable over time, both nationally and provincially, at around five to six per cent of live births.

Figure 4b. Low Birth Weight, Manitoba and Canada, 1979 – 2001.



Source: Statistics Canada, Vital Statistics

Notes:
1. Only includes infants weighing less than 2,500 g but more than 500 g

Common or chronic disorders

Chronic diseases represent a major and growing burden in our population. The most common chronic diseases include cardiovascular disease, diabetes, cancer, chronic obstructive pulmonary disease (COPD), asthma and mental illness. This section of the report describes the comparative rates and mortality for some major chronic diseases, all of which have risk factors that may be modifiable through social, environmental, and lifestyle changes and many of which are preventable. It also presents information on conditions such as sexually transmitted infections and injuries, which are largely preventable.

Cardiovascular Disease: Heart Attack and Stroke

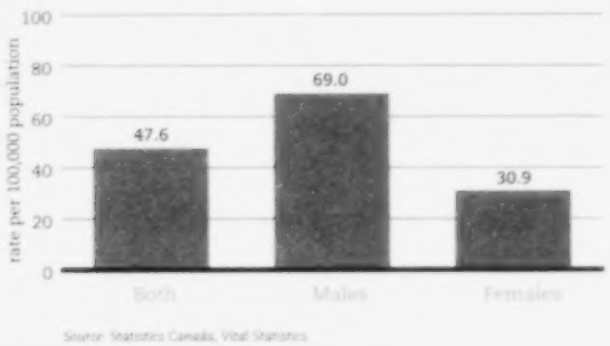
Cardiovascular disease, which includes heart attacks (acute myocardial infarction or AMI) and stroke, is one of the leading causes of death among Canadians and the underlying cause of death for one in three Canadians.[1]

Heart attack risk factors:
- smoking
- stress
- diabetes
- high blood pressure
- abdominal obesity
- lack of exercise
- excessive alcohol intake
- low fruit and vegetable consumption
- blood lipoprotein ratio APOA1:APOB

While cardiovascular disease is a leading cause of death, it may be prevented or its onset delayed. Approximately 80 per cent of the population has at least one modifiable risk factor for cardiovascular disease[2]. Sedentary lifestyles and a diet high in saturated fats are associated both with obesity and cardiovascular disease. Recent research has shown that nine key risk factors – most of which can be influenced by healthy living – are associated with nine out of 10 heart attacks (see text box)[3].

Mortality rates for heart attack

In Manitoba in 2001, the age-standardized mortality rate for heart attack was 47.6 deaths per 100,000 population (Figure 5a). The rate for men was more than twice that for women (69.0 deaths/100,000 population for men compared to 30.9 for women).



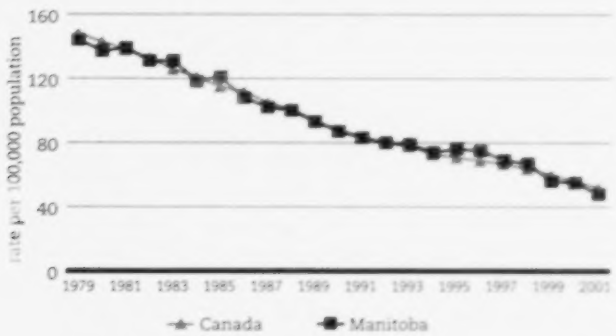
Source: Statistics Canada, Vital Statistics

Figure 5a. Age-standardized Mortality Rate for AMI by Sex, Manitoba, 2001.

[1] The Growing Burden of Heart Disease and Stroke in Canada, 2003
[2] "Effects of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study" Yusuf et al, Lancet 2004; 346(9437)

Since 1979, the age-standardized mortality rate for heart attack, in both Manitoba and Canada, has declined dramatically from about 140 deaths per 100,000 to about 50 (Figure 5b).

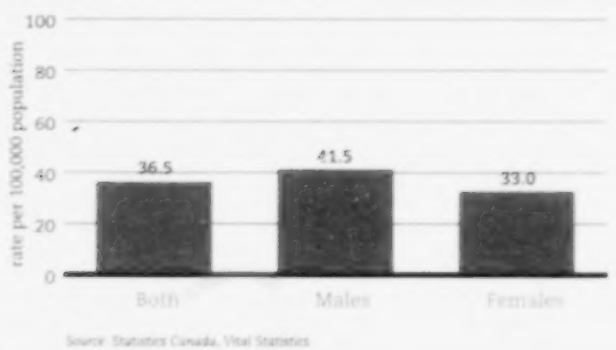
Figure 5b. Age-standardized Mortality Rate for AMI, Manitoba and Canada, 1979 - 2001.



Mortality rates for stroke

In 2001, Manitoba's age-standardized mortality rate for stroke was 36.5 deaths per 100,000 population (Figure 6a). Unlike the mortality rate of heart attack, deaths due to stroke are not more common among men; male and female mortality rates are relatively similar.

Figure 6a. Age-standardized Mortality Rate for Stroke by Sex, Manitoba, 2001.



As observed for heart attack, the standardized mortality rate for stroke has declined over time from about 65 deaths due to stroke per 100,000 population in 1979, to about 35 deaths per 100,000 population in 2001 (Figure 6b).

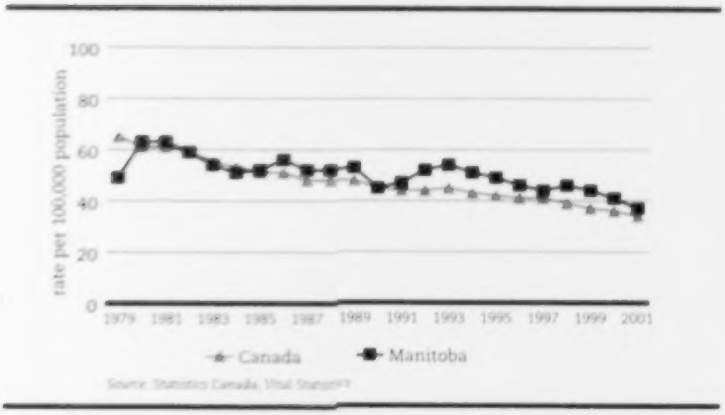


Figure 6b. Age-standardized Mortality Rate for Stroke Manitoba and Canada, 1979-2001.

Cancer

Lung cancer incidence and mortality

Lung cancer is among the most common forms of cancer in Canada, and the most frequent cause of cancer deaths with 18,900 deaths in 2004[1]. In Manitoba, about 60 new cases of lung cancer are diagnosed every year per 100,000 population (Figure 7a). This rate is much higher for men than women (76.7 new cases per 100,000 population for men compared to 46.6 for women), with the male rate about 1.6 times higher than that for females.

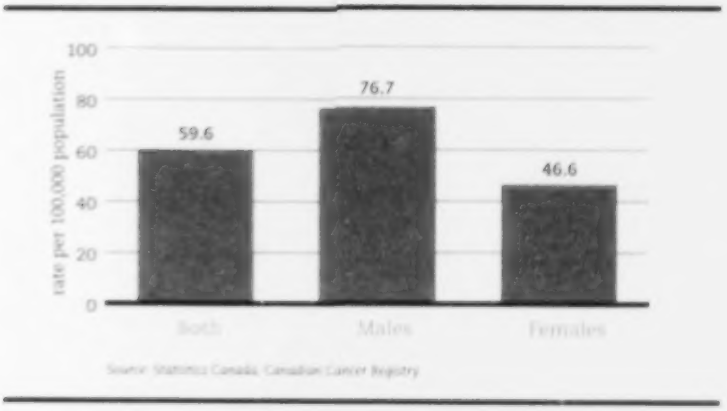


Figure 7a. Age-standardized Incidence of Lung Cancer, by Sex, Manitoba 2000.

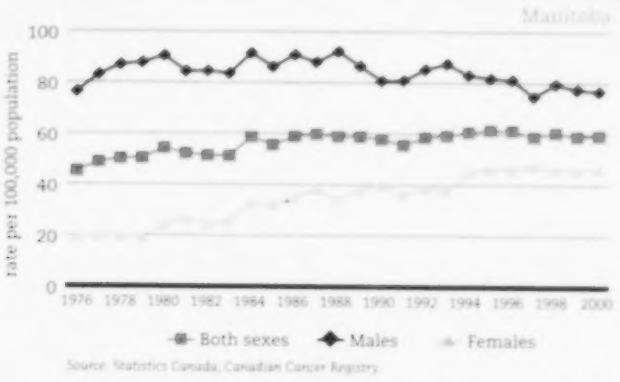
[1] Canadian Cancer Statistics, 2004

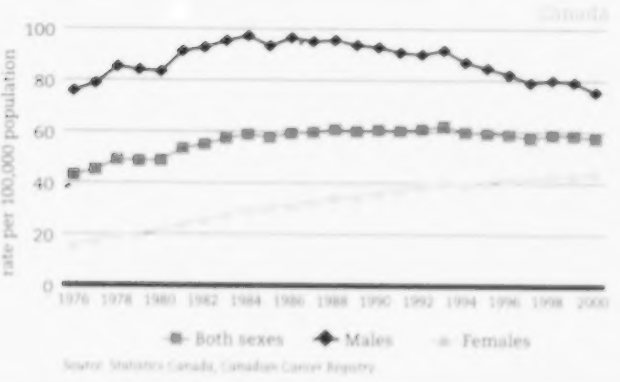
Although the time trend in Figure 7b shows an increase in the number of newly diagnosed cases of lung cancer between 1976 and 2000, the number of new cases of lung cancer, both in Canada and Manitoba, has leveled off since the mid-1980s.

In any given year, more men than women will be diagnosed with lung cancer. However, looking at the number of new cases by gender over time, there is a large increase in lung cancer diagnoses among women (both nationally and provincially), from about 15 to 20 per 100,000 new cases a year in 1976 to approximately 45 per 100,000 new cases per year in 2000.

Readers should be cautious when interpreting these data. See data clarification (page 61).

Figure 7b. Age-standardized Incidence of Lung Cancer, by Sex, Manitoba and Canada, 1976-2000.





As with the number of newly diagnosed lung cancer cases, the age-standardized mortality rate for lung cancer is higher for men than women (Figure 7c). In 2001, there were 58 deaths from lung cancer per 100,000 population among Manitoba males compared to 35 deaths per 100,000 population for females.

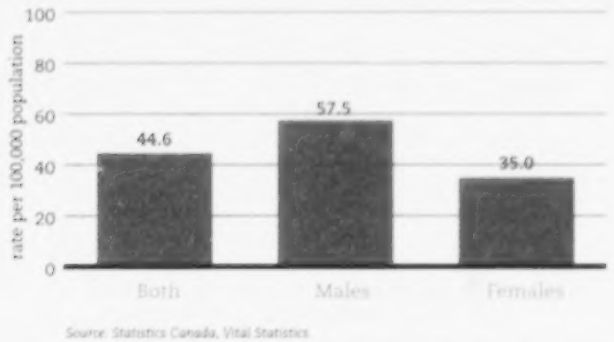


Figure 7c. Age-standardized Mortality Rate for Lung Cancer, by Sex, Manitoba, 2001.

Looking at deaths due to lung cancer over time, since the mid-1980s, the age-standardized mortality rate for lung cancer has leveled off for both Canada and Manitoba at approximately 45 deaths per 100,000 population (Figure 7d).

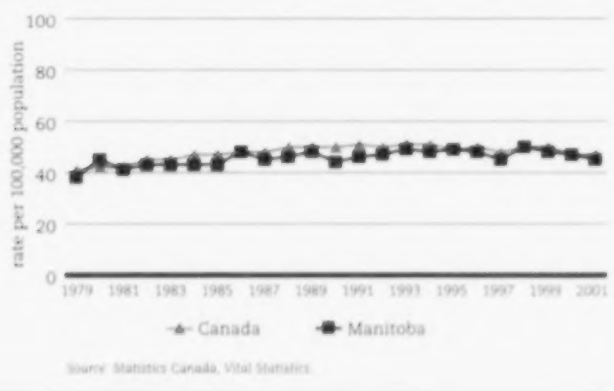


Figure 7d. Age-standardized Mortality Rate for Lung Cancer, Manitoba and Canada, 1979-2001.

Breast cancer

Breast cancer is the most common cancer affecting women in Canada and has the second highest mortality rate, behind lung cancer[1]. In 2001, the age-standardized mortality rate for female breast cancer was 23 deaths per 100,000 Manitoban women (25 deaths per 100,000 for Canadian women).

Over time, from a national perspective, deaths due to breast cancer in women have declined slightly from about 30 deaths per 100,000 population in 1979 to about 25 in 2001 (Figure 8). The Manitoba rate has been more variable.

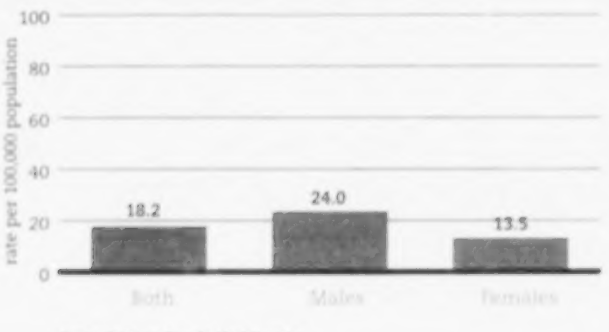
Figure 8. Age-standardized Mortality Rate for Female Breast Cancer, Manitoba and Canada, 1979-2001.

Source: Statistics Canada, Vital Statistics

Colorectal cancer

Colorectal cancer is the second leading cause of cancer deaths in Canada.[1] Figure 9a shows the age-standardized mortality rates for colorectal cancer in Manitoba. The mortality rate is almost twice as high for men as it is for women – 24 deaths due to colorectal cancer per 100,000 population for men compared to 13.5 deaths for women. The rate has decreased steadily over time, both nationally and provincially, from 24 to 26 deaths per 100,000 population in 1979, to about 18 deaths in 2001 (Figure 9b).

Figure 9a. Age-standardized Mortality Rate for Colorectal Cancer, by Sex, Manitoba, 2001.



Source: Statistics Canada, Vital Statistics

[1] National Cancer Institute of Canada. Canadian Cancer Statistics, 2004

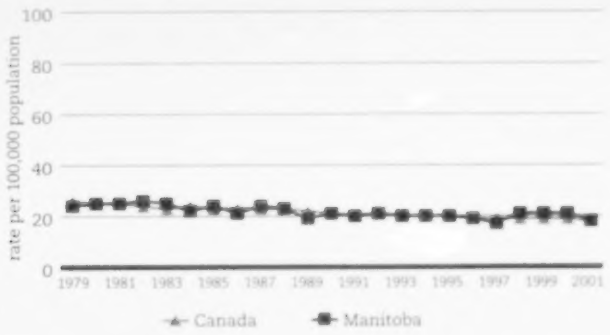


Figure 9b. Age-standardized Mortality Rate for Colorectal Cancer, Manitoba and Canada, 1979-2001.

Diabetes

When considering progress with respect to health conditions, there is a tendency to focus on incidence (the number of newly diagnosed cases) and mortality rates (the number of people dying from a condition). However, the number of people living with a condition (prevalence) is also an important indicator.

A high prevalence of a chronic disease does not necessarily mean more people are getting the disease. It may mean that we are doing a better job of identifying people who have the disease and/or treating the disease so that those who have it are living longer. Regardless of the reason, information on prevalence is important to determine the need for health services aimed at addressing a specific health condition.

Figure 10a shows the age-standardized prevalence of diabetes in Manitoba and Canada, by gender. Almost six per cent of Manitoba males over the age of 20 are living with diabetes and about five per cent of Manitoba women. The comparable Canadian values are 5.2 per cent of Canadian males and 4.4 percent of Canadian females.

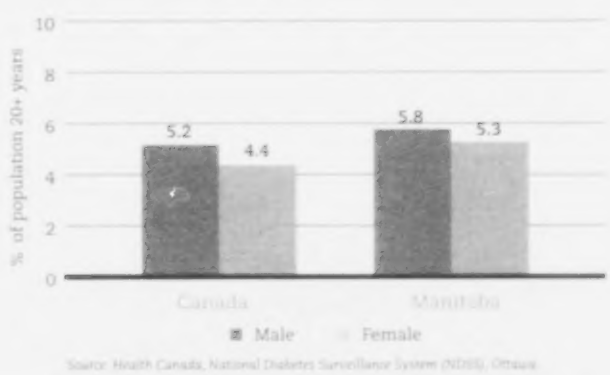
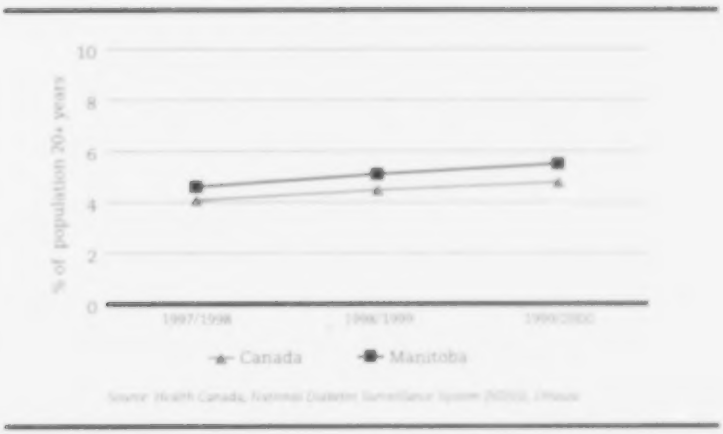


Figure 10a. Age-standardized Per cent of Adult Population who have Diabetes, by Sex, Manitoba and Canada, 1999/2000.

Over the relatively brief three-year period from 1997-1998 to 1999-2000, the proportion of adults with diabetes increased from 4.1 per cent to 4.8 per cent in Canada and from 4.6 per cent to 5.5 per cent in Manitoba (Figure 10b). This higher prevalence of diabetes in Manitoba compared to Canada may be due to the higher proportion of First Nations people in Manitoba (approximately 14 per cent compared to about three per cent for Canada[1]), as this group tends to have an increased rate of diabetes. Readers should be cautious when interpreting these data. See data clarification (page 61).

Figure 10b. Age and Sex-standardized Per cent of Adult Population who have Diabetes, Manitoba and Canada, 1997/98 - 1999/00.



Source: Health Canada, National Diabetes Surveillance System (NDSS), Ottawa.

Mental Health

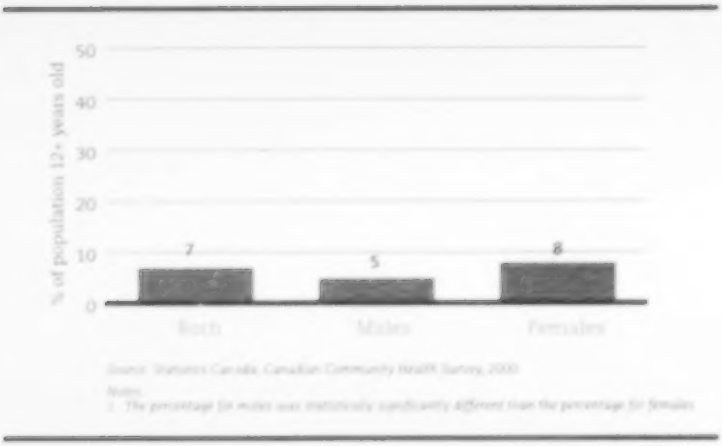
Mental health is fundamental to an individual's overall health and the health of communities. It is essential to personal well-being and the ability to lead a healthy, balanced and productive life. Mental disorders often occur in younger people and their frequency and chronic course make them a notable cause of disability.

According to the World Health Organization, five of the 10 leading causes of disability are related to mental disorders. It predicts that in less than 20 years, depression will be the second-leading cause of disability in the world[2]. Two major areas of concern, depression and suicide, are discussed below.

Depression

Figure 11a shows an estimate of the prevalence of depression in Manitoba. These data were derived from the Canadian Community Health Survey (2000). In the 12 months preceding the survey, significantly more women than men were likely to be depressed (eight per cent of women and five per cent of men).

[1] Data from 2001 Census.
[2] World Health Organization. Solving the 'gap' in mental health. Bull World Health Organ 2000; 78:500.
[3] Census population 0-74: 1,078,801. Overall rate: 375.4/100,000.



Source: Statistics Canada, Canadian Community Health Survey, 2000

Notes:
1. The percentage for males was statistically significantly different from the percentage for females

Figure 11a. Per cent who are Likely Depressed, Manitoba, 2000

Again, it is important to note that the CCHS gathers information on a representative sample of individuals aged 12 years and older who live in private households. However, this sample excludes some important groups of individuals and may have implications for interpretation of the data. Not included in the survey are Manitobans who live on First Nations reserves and Crown lands, residents of institutions (such as personal care homes), full-time members of the Canadian Armed Forces and residents of some remote regions.

Potential years of life lost is the number of years of life lost when a person dies prematurely

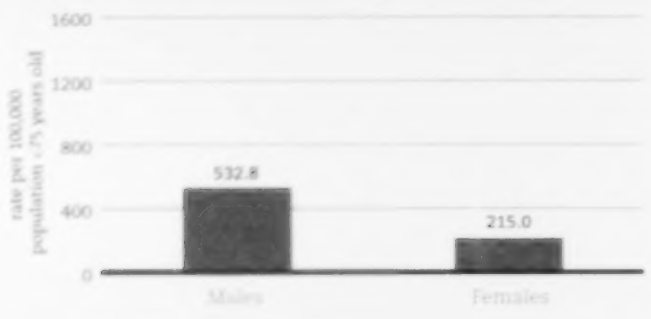
The value is large for those conditions that are common and that affect younger people.

Potential years of life lost due to suicide

Potential years of life lost (PYLL) is a way of looking at the impact of a condition on the population. PYLL is the number of years of life lost when a person dies prematurely (a premature death is defined as one occurring before 75 years of age). The value for potential years of life lost is large for those conditions that are common and that affect younger people. For rare conditions, or those that affect older individuals, the number of potential years of life lost is smaller.

The most extreme outcome of depression is suicide. Figure 11b shows the rate of potential years of life lost in Manitoba, due to suicide, in 2001. The overall rate of PYLL was 375 years per 100,000 population (for both genders). In other words, about 4,028 potential years of life were lost in Manitoba in 2001 due to suicide. The PYLL rate for males is more than double that for females: 533 years per 100,000 population for Manitoba males younger than 75 years of age, females 215. This higher rate of PYLL due to suicide for males suggests that either more males commit suicide, or that they do so at a younger age than do females.

Figure 11b. Rate of Potential Years of Life Lost due to Suicide, Manitoba, 2001



Source: Statistics Canada, Vital Statistics

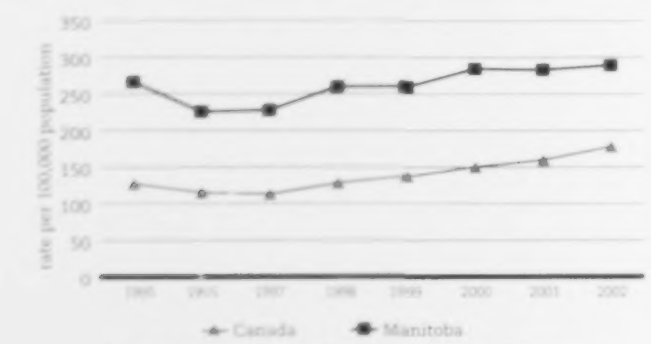
Sexually Transmitted Infections

Sexually transmitted infections include diseases such as gonorrhea, chlamydia, syphilis and HIV. These are important disease prevention targets as the diseases and their complications (such as infertility, pelvic inflammatory disease or other serious illness) are serious. This report includes only chlamydia.

Chlamydia

Figure 12 shows the incidence of chlamydia, a common sexually transmitted infection, for Manitoba and Canada between 1995 and 2002. Incidence rates are increasing both provincially and nationally; the Manitoba incidence in 2002 was 289 new cases[1] per 100,000 (the Canadian rate, approximately 179 per 100,000). Over time, the Manitoba rate has consistently been higher than the national rate. The difference between the Manitoba and national rates may in part be due to differing age distributions, and levels of diagnosis and reporting.

Figure 12. Chlamydia Incidence (Crude Rates), Manitoba and Canada, 1995 - 2002



Source: Sexual Health and Sexually Transmitted Infections Section, Community Acquired Infections Division, Centre for Infectious Disease Prevention and Control, Health Canada

Notes:
1. 2001 and 2002 rates are considered preliminary.

[1] These represent cases not individuals. An individual may be tested and test positive more than once for chlamydia. Each test would be identified as a case.

Unintentional Injuries

The final category of conditions presented is unintentional injury (that is, injuries that do not include suicide or violence inflicted by others). As with suicide, injury data is commonly represented using potential years of life lost (PYLL). Figure 13 shows the PYLL due to unintentional injuries for Manitoba and Canada in 2001. Males in Manitoba and Canada appear to have a much higher PYLL rate due to unintentional injury than females – almost three times higher. Manitoba's unintentional injury PYLL is higher than the Canadian values both for males and females, as well as overall (938 vs. 585 years per 100,000 population aged less than 75 years).

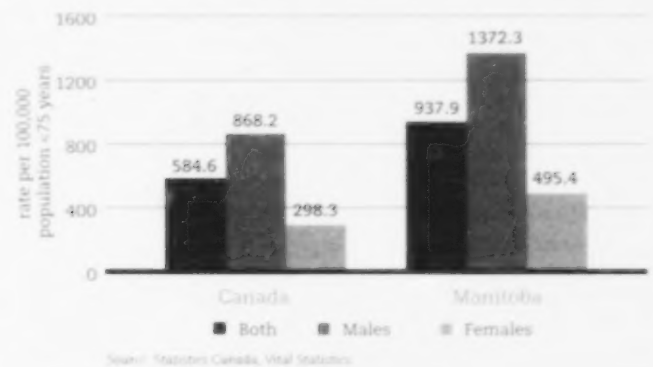


Figure 13. Rate of Potential Years of Life Lost due to Unintentional Injury, Manitoba and Canada, 2001.

Activities that can prevent or delay the onset of chronic disease include:

- *eating healthy foods*
- *stopping smoking*
- *drinking less alcohol*
- *being more active.*

For families:

- *watching less television*
- *going for walks or bike rides*
- *preparing and eating meals together.*

Maintaining good health

With most diseases, modifiable risk factors play an important role. A considerable portion of chronic diseases can be prevented or their onset delayed by choosing certain activities or behaviours over others. Recent international research has provided even stronger evidence that stopping smoking, eating healthy foods and being physically active can greatly lower the risk of heart attacks, diabetes and some cancers.

Previously, this report examined the health of Manitoba's population as a whole by looking at life expectancy, infant mortality and low birth weight. The following indicators also can be used to gauge the overall health and well-being of Manitobans. These three indicators are largely influenced by social and other environmental factors, as well as by personal behaviours:

- Body Mass Index (BMI)
- physical activity
- smoking

Body Mass Index (BMI)

Body Mass Index or BMI is a common method of determining if an individual's weight falls within a healthy range.

Healthy bodies come in all sorts of different shapes and sizes. The key to a healthy weight is to balance the amount and type of food consumed against an appropriate level of activity. The Body Mass Index (BMI) is a common method of determining if a person's weight falls within a healthy range, according to their height.

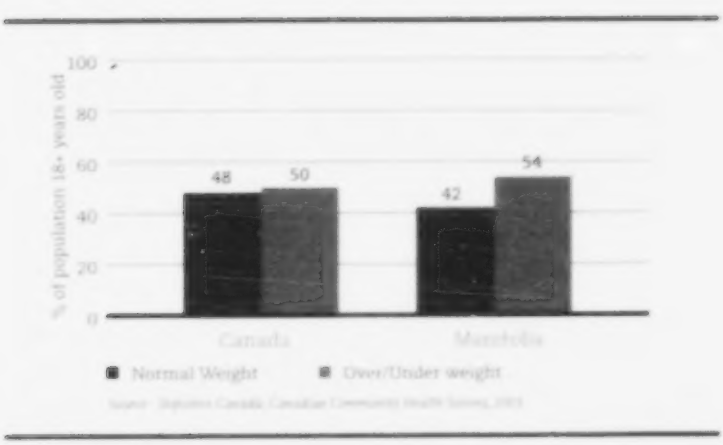
BMIs between 18.5 and 24.9 are considered ideal. Lower than that, an individual is considered underweight; between 25 and 29.9 is considered overweight; and a BMI of 30 or more is considered obese. A tool to calculate BMI is available at: http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/bmi_chart_java_e.html

There has been such a large increase in the number of overweight and obese Canadians in the last 20 years, and the health consequences are so significant, that obesity is now considered to be an epidemic. Of particular concern is the rate of obesity among children and among First Nations peoples[i].

Being overweight can result in raised blood pressure and blood cholesterol levels. It can also lead to diabetes. Recently, obesity has been linked with the development of cancers of the colon, breast cancer (after menopause), endometrium, kidney and esophagus. It is estimated that excess body weight could be associated with 14 to 20 per cent of all cancer deaths.[ii]

So, how are Manitobans doing with respect to their weight? Figure 14a shows the distribution of weight for Manitobans and for Canadians. Forty-two per cent of Manitobans surveyed had an ideal or "normal" healthy weight, compared to 48 per cent nationally. Thirty-four per cent of Manitobans surveyed were overweight and approximately 18 per cent obese (Figure 14b). As Figure 14b shows, there are also significant gender differences in weight; the Manitoba men surveyed were significantly more likely than the women to be overweight or obese.

Figure 14a. Age-standardized Per cent of Population with Normal BMI, Manitoba and, Canada, 2003



Source: Statistics Canada, Canadian Community Health Survey, 2003

[i] Overweight and Obesity in Canada: A Population Health Perspective (CIHI, August 2004)

[ii] Calle et al, 2003. "Overweight, obesity and mortality for cancer in an prospectively studied cohort of US adults." New England Journal of Medicine 348(17):1625-38. See also, Calle and Thun, 2004. "Obesity and cancer." Oncogene 23(38):6365-78.

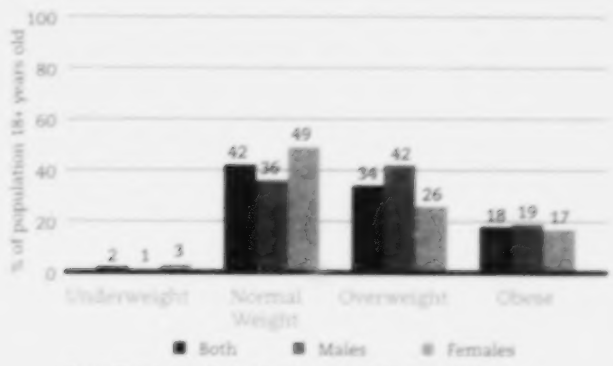


Figure 14b. Body Mass Index by Sex, Age-standardized Per cent of Population, Manitoba, 2003.

It is important to note that the survey data upon which these findings are based does not include First Nations people. Very limited data about obesity exists for this group, but some small studies have suggested that the obesity rate among First Nations may be double that seen in non-First Nation populations[9]. First Nations individuals comprise a much larger percentage of the Manitoban population relative to Canada (13.6 per cent vs. 3.3 per cent for Canada[10]), so the proportion of overweight and obese Manitobans may be significantly underestimated by these figures. As well, these data are based on self-reported height and weight and evidence suggests that these are likely underestimated. Pregnant women are also excluded from the data.

When obesity is examined over time, there is a statistically significant increase in the proportion of obese Canadians, with the proportion rising from 13 per cent in 1994 to 15 per cent in 2003 (Figure 14c). In 1994, Manitoba's obesity rate was the same as the Canadian rate for 2003. By 2003, 18 per cent of Manitobans surveyed were considered to be obese.

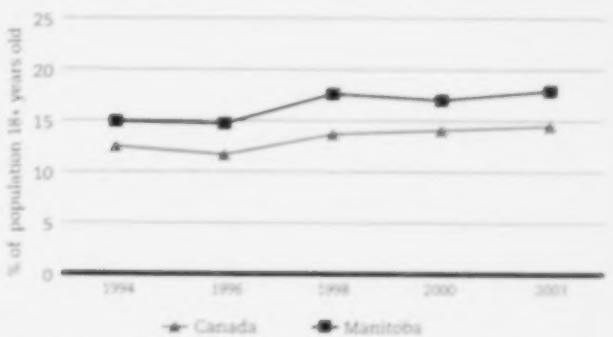


Figure 14c. Age-standardized Per cent of Population Who Reported a Body Mass Index of 30.0 or Higher (Obese), Manitoba and Canada, 1994 - 2003.

[9] Data from 2001 Census

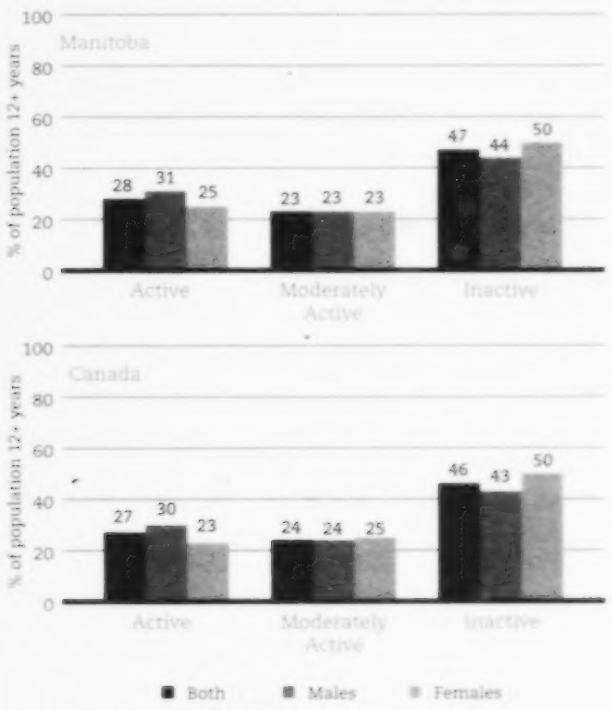
Physical activity

Physical activity reduces stress, increases energy, and helps in achieving and maintaining a healthy body weight – all important factors in living a healthy lifestyle.

Figure 15a shows activity levels among Manitobans and Canadians surveyed for the Canadian Community Health Survey. Respondents were classified as active, moderately active or inactive based on recall of their physical activity in the three months prior to the survey. In the 2003 survey, less than 30 per cent of Manitobans surveyed reported being physically active and almost half (47 per cent) reported being inactive.

Significantly fewer Manitoba women reported being active (25 per cent vs. 31 per cent for males) and significantly more reported being inactive (50 per cent vs. 44 per cent for males). Recent research suggests that, for women, being less active increases the risk of heart disease even more than being overweight[1].

Figure 15a. Age-standardized Per cent of Population, by Physical Activity Level and Sex, Manitoba and Canada 2003.

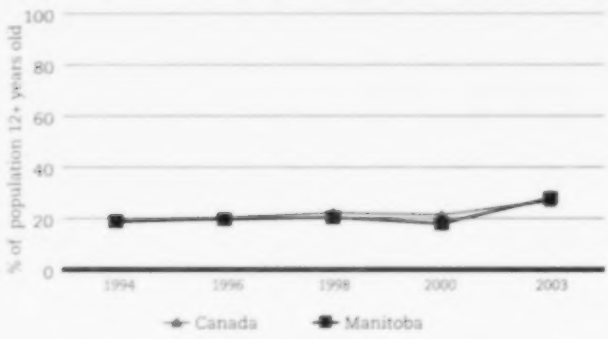


Source: Statistics Canada, Canadian Community Health Survey, 2003

Notes:
1. Percentages for Manitoba males were statistically significantly different than percentages for Manitoba females in the 'Active' and 'Inactive' categories.
2. Percentages for Canada males were statistically significantly different than percentages for Canada females in all Activity categories.

[1] 'Relationship of Physical Fitness vs. Body Mass Index With Coronary Artery Disease and Cardiovascular Events in Women.' Wessel et al. JAMA 292:1179-87, 2004

Both Manitoba and Canada showed similar (and significant) increases in individual activity levels over time. In 1994, approximately 19 per cent of both Manitobans and Canadians surveyed indicated that they were physically active compared to 27 to 28 per cent in 2003 (Figure 15b).



Source: Statistics Canada, Canadian Community Health Survey, 2000/01 & 2003; National Population Health Survey, 1994/95 & 1998/99

Notes:
1. Canada and Manitoba rates for 2003 are statistically significantly different than Canada and Manitoba rates for 1994.
2. Changes over time for this indicator should be interpreted with caution due to a change in mode of data collection between 2001 and 2003.

Figure 15b. Age-standardized Per cent of Population, who reported being Physically Active Manitoba and Canada 1994-2003.

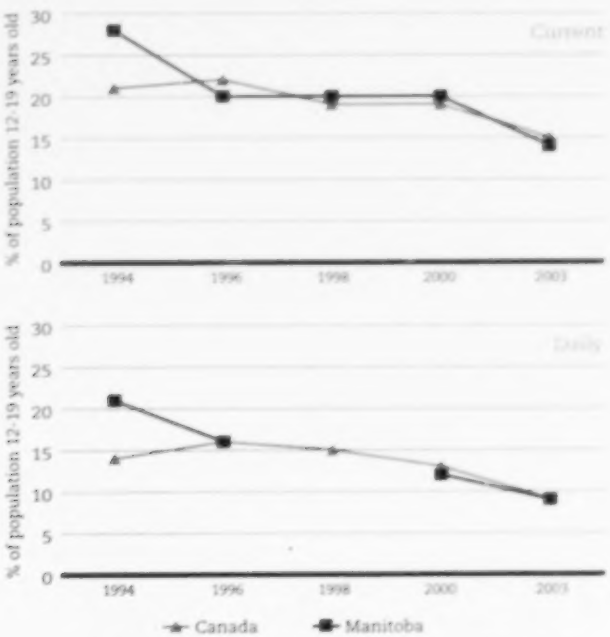
Smoking among youth

Tobacco use is a major cause of preventable illness and death. In addition to the burden of lung cancer as a consequence of smoking, other diseases including COPD, heart disease, other cancers, etc. are associated with smoking. A recent World Health Organization (WHO) study showed that smokers under the age of 40 were five times more likely to have a heart attack than non-smokers, and that about 80 per cent of people aged 35 to 39 who had heart attacks were smokers[17].

Since 1994, self-reported tobacco use among Canadian and Manitoban teens has declined (Figure 16a, Current Smoker). Of the current smokers, about two-thirds, both in 1994 and in 2003, indicated that they smoked daily (Figure 16a, Daily smoker). In 2003, 14 per cent of Manitoba teens indicated that they were current smokers and nine per cent, or two-thirds of the current smokers, indicated they were daily smokers. Much of the Manitoba data for youth smoking is based on a relatively small number of responses. Where this is the case, it is indicated in the notes that accompany the figure: these data should be interpreted with caution.

[17] "Current smoking and the risk of non-fatal myocardial infarctions in the WHO MONICA project populations" Makonen et al, Tobacco Control 2004; 13:244-250

Figure 16a. Per cent of Teen Population who are Current or Daily Smokers, (Crude Percentage) Manitoba and Canada, 1994-2003.

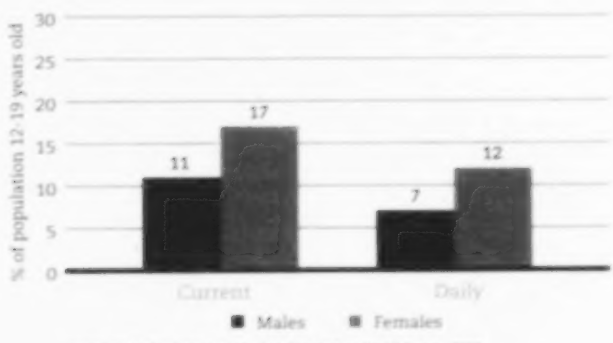


Source: Statistics Canada, Canadian Community Health Survey, 2000/01 & 2003; National Population Health Survey, 1995 to 1999

Notes:
1. Denominator is the percentage of the population aged 12-19
2. Daily smokers are a subset of current smokers
3. Manitoba data for 1998 was too unreliable to be published
4. Current percentages for Manitoba in 1994 and 1998 should be interpreted with caution
5. Daily percentages for Manitoba in 1994 should be interpreted with caution
6. Percentages for Canada for both Current and Daily smokers in 2003 were statistically significantly different than percentages for Canada in 1994
7. Percentage for Manitoba for Current smokers in 2003 was statistically significantly different than percentage for Manitoba in 1994

In 2003, approximately 17 per cent of the Manitoba teenage girls surveyed and 11 per cent of teenage boys indicated that they were current smokers (Figure 16b). *Due to the small number of responses upon which these data are based, the numbers for current teenage male smoking and all the daily smoking information should be interpreted with caution.*

Figure 16b. Per cent of Teen Population who are Current or Daily Smokers, by Sex, (Crude Percentage) Manitoba, 2003.



Source: Statistics Canada, Canadian Community Health Survey, 2003

Notes:
1. Denominator is the percentage of the population aged 12-19
2. Daily smokers are a subset of current smokers
3. Data for current Manitoba male smokers and all daily smokers should be interpreted with caution

Second-hand smoke

Although the number of individuals who smoke is declining, many people continue to be exposed to second-hand smoke. Figure 17 shows the proportion of individuals who indicated that they had been exposed to second-hand smoke in the month prior to being surveyed, by location of the exposure.

About 20 per cent of the Manitobans surveyed indicated that they had been exposed to second-hand smoke in a public place; 11 per cent indicated that they had encountered second-hand smoke in the home and in vehicles. Generally, men reported higher levels of exposure to second-hand smoke than did women, although none of the differences were statistically significant.

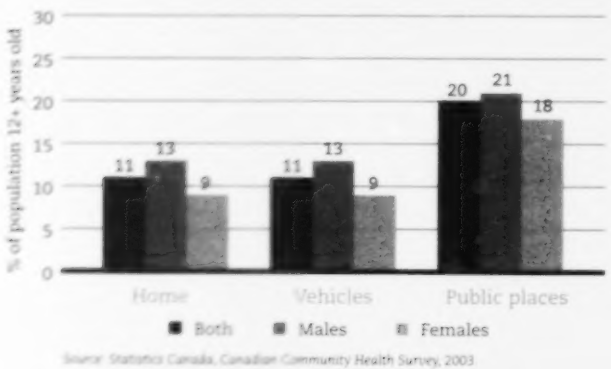


Figure 17. Per cent of Population Exposed to Second-hand Smoke in the Last Month, by Location and Sex, (Crude Percentage) Manitoba, 2003.

Screening and prevention

In addition to lifestyle modifications, annual check-ups, screening and preventive measures such as vaccinations are also important for staying healthy. In a 2003 survey, 86 per cent of Manitobans (85 per cent of Canadians) reported having a regular family doctor[14]. Family physicians play an important role in maintaining, as well as improving health. During preventive visits, they have a chance to discuss personal risk factors and health goals with their patients, while regular check-ups allow general practitioners to screen for early signs of health problems, and offer other preventive services such as immunizations.

PAP testing

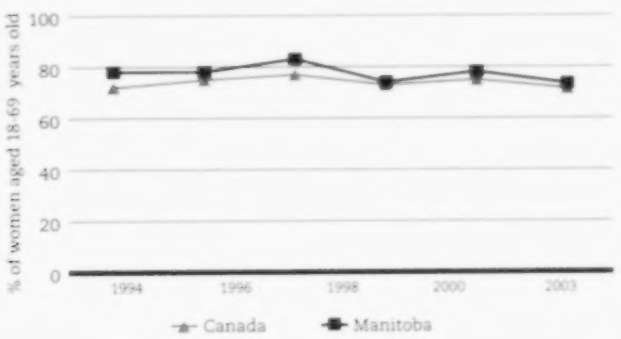
Figure 18 shows the proportion of women who received a PAP test within the last three years (the recommended frequency for this type of screening) for each of the years indicated. PAP testing is one of the most successful cancer screening tools. If the screen is performed regularly, it detects up to 90 per cent of cervical cancers early in their development. Treatment at an early stage is usually effective.

[14] Health Services Access Survey, 2003. The difference between the Manitoban and Canadian rates is not significant.

In 2003, 78 per cent of Manitoba women who should have had a PAP smear did so (screening is only recommended for women aged 18 to 69). The comparable Canadian value was 75 per cent. This difference is statistically significant. Since 1994, there has been a statistically significant increase in the proportion of women being screened nationally.

PAP testing is a screen for cervical cancer and is recommended once every three years for women aged 18 to 69 years.

Figure 18. Age-standardized Per cent of Females who had a PAP Smear test within the Last Three Years, Manitoba and Canada, 1994-2003.



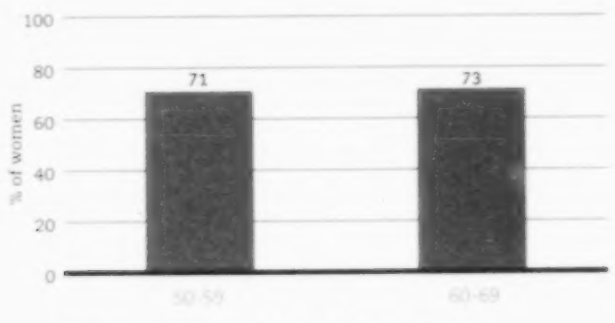
Source: Statistics Canada, Canadian Community Health Survey, 2003; 2000-01, health file; Statistics Canada, National Population Health Survey, 1994/95, 1996/97 and 1998/99, cross sectional sample, health file; Statistics Canada, National Population Health Survey, 1994/95 and 1996/97, cross sectional sample, North component

Notes:
1. Percentage for Canada in 2003 was statistically significantly different than percentage for Canada in 1994.
2. Percentages for Manitoba in 1994 and 2003 were statistically significantly different than the percentages for Canada in those same years.

Mammography

Screening mammography is used to detect early breast cancer in women at increased risk because of their age. In Manitoba, it is recommended that screening mammography be offered every two years to all women 50 to 69 years of age (although it may be offered to younger women based on a positive family history of breast cancer). Figure 19 shows the proportion of Manitoba women receving at least one mammogram (screening or other) by age group. About 71 per cent of women aged 50 to 59 had at least one mammogram in the two years prior to 2003, and 73 per cent for the women in the 60 to 69 year age group.

Figure 19. Per cent of Female Population who had a Mammogram Within the Last Two Years, by Age Group, (Crude Percentage) Manitoba, 2003.



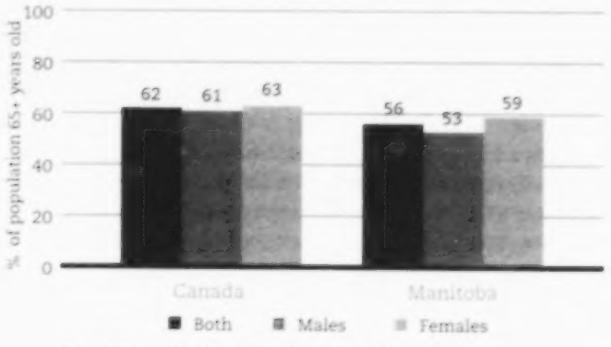
Source: Statistics Canada, Canadian Community Health Survey, 2003

Influenza immunizations

Influenza (the flu) is a common respiratory illness that affects millions of Canadians each year. In Canada, flu season generally runs from November to April. The flu is very contagious and can cause serious illness and even death, especially in the elderly, the very young and those with chronic medical conditions.

This survey-based indicator reports the percentage of individuals aged 65 years or older who received an influenza immunization within the last year. As indicated in Figure 20, over half of survey respondents both nationally and provincially reported having received a recent flu immunization. Specifically, 56 per cent of Manitobans and 62 per cent of Canadians aged 65 years or older reported having been immunized. The Manitoba rate is significantly lower than the Canadian rate, primarily due to fewer flu immunizations among male seniors (53 per cent compared to 61 per cent).

These survey-based numbers underestimate the actual number of Manitoban and Canadian seniors who received vaccinations, as the survey on which they were based does not include personal care home residents. Since 1999, Manitoba Health's influenza vaccination campaign has specifically targeted individuals living in personal care homes as a key "at-risk" group. Data for 2003, from Manitoba's immunization database (the Manitoba Immunization Monitoring System or MIMS), show that the actual influenza coverage rate for Manitobans aged 65 years or older – including residents of personal care homes – was 68 per cent.



Source: Statistics Canada, Canadian Community Health Survey, 2003.
Notes:
1. Manitoba males are significantly statistically different from Canadian males.
2. The overall Manitoba percentage is significantly statistically different from the overall Canadian percentage.

Figure 20. Age-standardized Per cent of Senior Population who had an Influenza Immunization Less Than One Year Ago, by Sex, Manitoba and Canada, 2003.

Access to health care services

Access to health care services was examined across a number of categories:

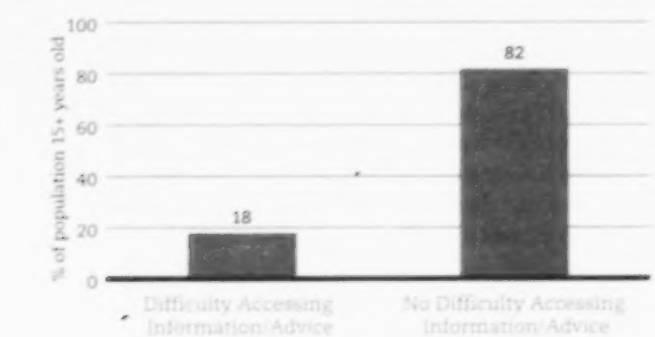
- access to health information or advice;
- access to primary health care, including
  - access to immediate care
  - access to routine care
  - rate of ambulatory sensitive conditions;
- wait times for diagnostic services; and
- drug expenditures.

Access to health information or advice

In the 2003 Health Services Access Survey (HSAS) conducted by Statistics Canada, people were asked if they had experienced any difficulties getting health information or advice for themselves or a family member in the past 12 months. In 2003, 47 per cent of Manitobans (42 per cent of Canadians) reported that they had required health information or advice in the preceding 12 months.

An estimated 82 per cent of those Manitobans reported no difficulty in obtaining the health information they needed (Figure 21).

Figure 21. Age-standardized Per cent of Population having Difficulty Accessing Information or Advice, Manitoba, 2003

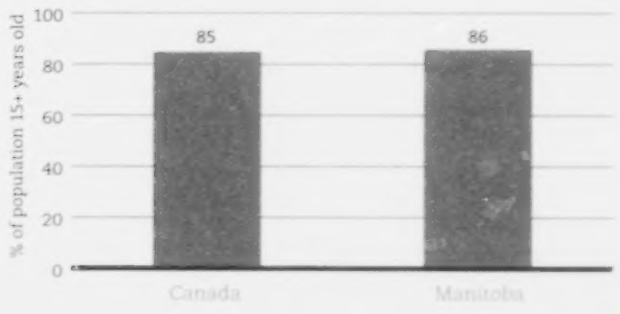


Source: Statistics Canada, Health Services Access Survey 2003

Access to primary health care

Access to a family doctor

In the 2003 Health Services Access Survey (HSAS), 86 per cent of Manitobans and 85 per cent of Canadians reported having a regular family doctor (Figure 22). This difference was not statistically significant.

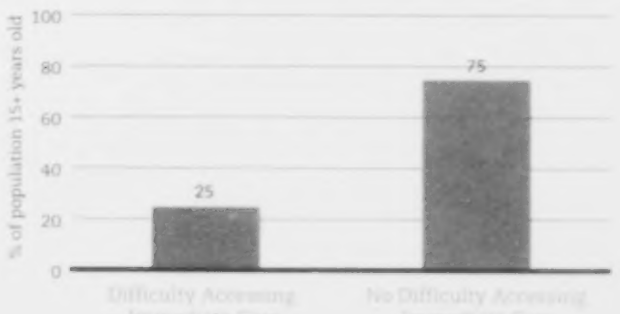


Source: Statistics Canada, Health Services Access Survey, 2003

Figure 22. Age-standardized Per cent of Population who Reported having a Regular Family Physician, Manitoba and Canada, 2003.

Access to immediate care

In 2003, an estimated 34 per cent of Manitobans (35 per cent of Canadians) reported that they had required immediate care for themselves or a family member in the preceding 12 months. As Figure 23 shows, about 75 per cent of those who sought immediate care for a minor ailment in the preceding 12 months, such as fever, headache, sprained ankle, vomiting or an unexplained rash, experienced no difficulty obtaining assistance. This was not statistically different from the Canadian average.



Source: Statistics Canada, Health Services Access Survey, 2003

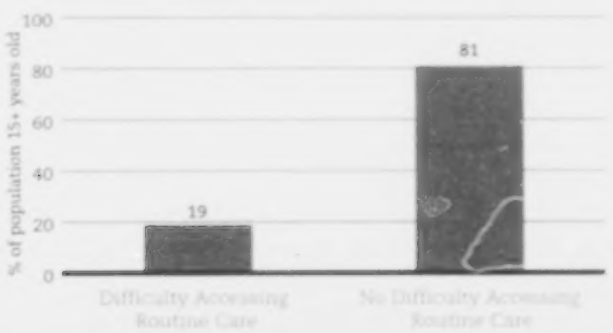
Figure 23. Age-standardized Per cent of Population having Difficulty Accessing Immediate Care, Manitoba 2003.

Access to routine care

The 2003 Health Services Access Survey also looked at routine medical care (a medical exam or follow-up) in the preceding 12 months. If individuals indicated that they had received routine care, they were asked if they had experienced any difficulties obtaining care.

In 2003, an estimated 54 per cent of Manitobans (57 per cent of Canadians) reported that they had required routine care for themselves or a family member in the preceding 12 months. Eighty-one per cent of those experienced no difficulty obtaining it (Figure 24).

Figure 24. Age-standardized Per cent of Population having Difficulty Accessing Routine Care, Manitoba, 2003.



Source: Statistics Canada, Health Services Access Survey, 2003

Ambulatory care sensitive conditions

Healthy living is about prevention – avoiding illness, or detecting and treating it early to minimize adverse health effects. An important consideration for access to health care is whether people are receiving the care they need in the community to keep them as healthy as possible. For example, are they being hospitalized unnecessarily when this could have been prevented if they had received the care they needed within a community setting? A commonly used indicator that measures this is the rate of ambulatory care sensitive conditions.

Ambulatory care sensitive conditions are those where hospitalization could likely be avoided through appropriate early disease management in a primary care setting, such as a doctor's office or community clinic. These conditions include diabetes, depression, hypertension and asthma. Not all admissions for ambulatory care sensitive conditions are avoidable; however, high hospital admission rates for these types of conditions may indicate that patients are not getting the care they need in their community.

Figure 25 shows the age-standardized rate of hospital admissions for ambulatory care sensitive conditions. Although over time the Manitoba rate has been consistently higher than the Canadian rate, both national and provincial rates are declining. Since 1995-1996, the Manitoba rate has declined by almost one-quarter from 597 admissions per 100,000 population to only 440 admissions per 100,000 population.

Looking at ambulatory care sensitive conditions by gender, in 2001-2002 the Manitoba rate was lower for women than for men: 426/100,000 population for women and 456/100,000 for men. Nationally, the rate was higher also for men: 367/100,000 population compared to 325/100,000 for women.

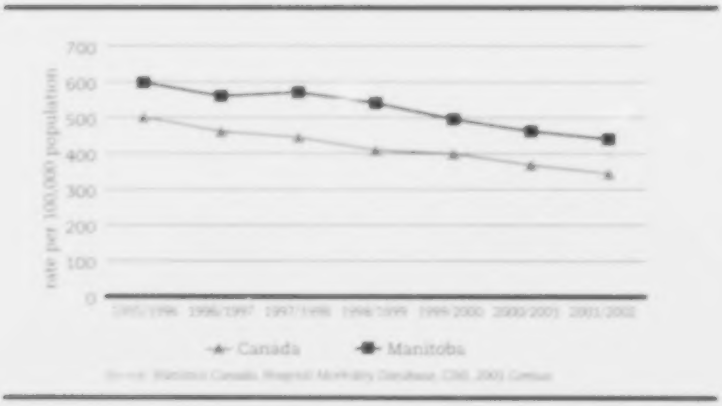


Figure 25. Age-standardized Rate of Ambulatory Care Sensitive Conditions, Manitoba and Canada, 1995/96 - 2001/02

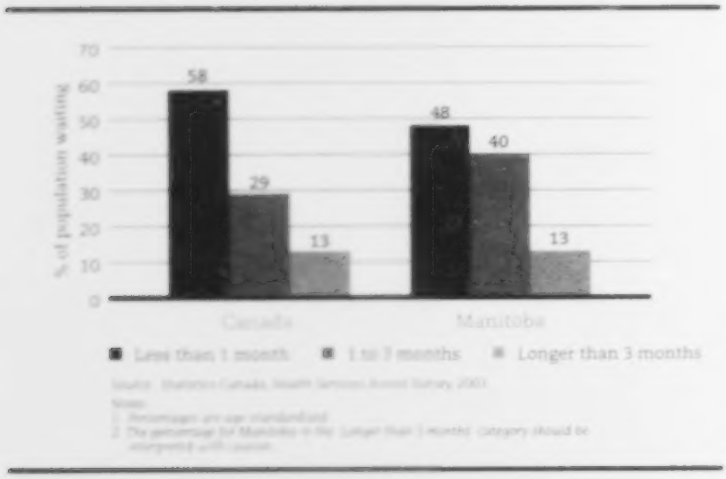
Wait times for elective diagnostic services

Not all illness is preventable, and when a person is sick they may need specialist services or diagnostic testing. Timely access to these is also important.

Figure 26 reflects the proportion of responses of the survey population who recalled waiting for elective (non-urgent) MRI or CT scans or angiography in the 12 months prior to the survey. In Manitoba, about 48 per cent of individuals surveyed who had a diagnostic procedure recalled waiting less than a month for the procedure, compared to 58 per cent nationally.

Both in Manitoba and nationally, approximately 87 per cent of individuals surveyed who required a non-emergent MRI, CT or angiography recalled that they waited less than three months for the procedure. The median wait time for elective diagnostic procedures was two weeks for Canada and four weeks for Manitoba. However, there is no statistically significant difference between these waiting times. These data should be interpreted with caution as they are based on only a small number of responses. Also, the data represent what respondents recollected about how long they waited, and do not include wait times for individuals still waiting for the procedure at the time of the survey.

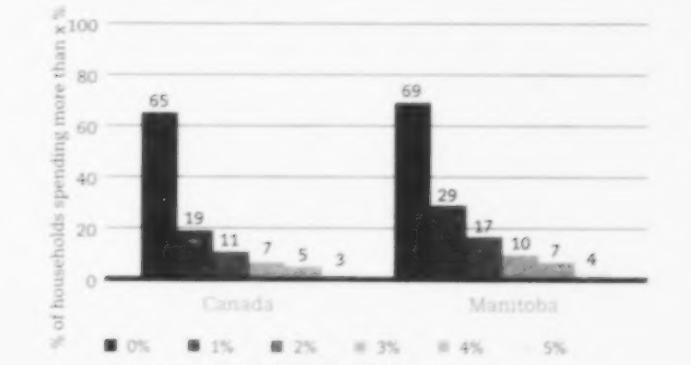
Figure 26. Self-Reported Wait times For Diagnostic Services, Manitoba and Canada, 2003.



Drug expenditures

A final indicator of access to health care is the proportion of households spending a significant portion of their income on prescription drugs. Many health conditions, particularly chronic diseases, require treatment with pharmaceuticals to cure or prevent the worsening of a condition. As drug expenditures become an increasing financial burden, individuals may be less likely to take their medications as prescribed, or avoid seeking treatment for other conditions that might require more prescriptions and an additional financial burden.

Figure 27 describes the proportion of household after-tax income spent on drugs in 2002. Over-the-counter drugs, and the portion of drugs paid for by governments or insurance companies are not included, nor are drugs obtained in hospital. The trend for Manitoba and Canada was similar; however, a significantly greater number of Manitoba households reported spending some portion of their after-tax income on prescription drugs (69 vs. 65 per cent). The differences between Manitoba and Canada were significant across all the categories reported with the exception of the "more than five per cent" group. The proportion of Canadian and Manitoban households spending more than five per cent of their after-tax income was comparable.



Source: Statistics Canada, Survey of Household Spending, 2002

Notes:
1. There was a statistically significant difference between the Manitoba and Canadian percentages for the first five categories.
2. The percent of households spending more than 5% did not differ between Manitoba and Canada.

Figure 27. Prescription Drug Spending as a Percentage of After-tax Income, (Crude Percentages) Manitoba and Canada, 2002.

PATIENT SATISFACTION AND QUALITY OF CARE RECEIVED

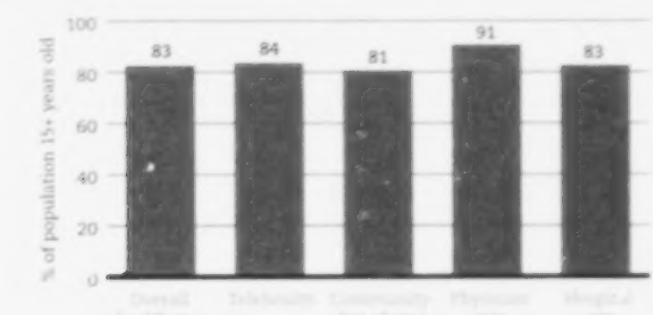
The (2003) Canadian Community Health Survey and the Health Services Access Survey included a number of questions about the perceived quality of different types of health care services, both community-based and in hospital, and patient satisfaction with these different types of care. Manitobans' responses are summarized below. Overall, a large proportion of Manitobans appear to be satisfied with the services they received and the quality of care provided.

In 2003, an estimated 95 per cent of Manitobans reported receiving some kind of health care service in the preceding 12 months. When asked to rate their satisfaction with the service, about 83 per cent said that they were very or somewhat satisfied with the way health care services were provided (Figure 28). An estimated 85 per cent of Manitobans rated the quality of care they received to be excellent or good (Figure 29).

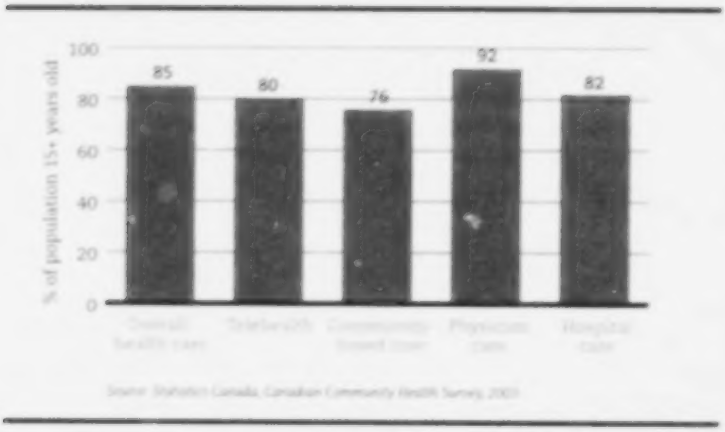
Similar questions were asked about satisfaction and quality for the following health services:

- telehealth,
- community-based care,
- physician care, and
- hospital care.

Figure 28. Age-standardized Per cent of Population who Reported they were Very or Somewhat Satisfied with Services Received, Manitoba, 2003.



Source: Statistics Canada, Canadian Community Health Survey 2003



Source: Statistics Canada, Canadian Community Health Survey, 2003

Figure 29. Age-standardized Per cent of Population who Reported Quality of Care as Excellent or Good, Manitoba, 2003.

Telehealth services

In the last five years, many provinces, including Manitoba, have developed both phone-in health lines and remote health conferencing abilities with a view to providing convenient, easily accessible health information. Manitoba's health "help line," Health Links-Info Santé, is a free, confidential bilingual health advice telephone line staffed by registered nurses 24 hours a day, seven days a week.

Another telehealth initiative in Manitoba designed to improve access to health information is the Family Doctor Connection phone line. Established in 2002, the phone line connects Winnipeggers with family physicians accepting new patients. Due to the success of the Winnipeg pilot, the initiative was expanded in March 2004 to include the rest of the province.

Manitoba's telehealth network is aimed at improving access to health information for Manitobans in rural and remote areas and their health care providers. Through the use of satellite video conference technology, residents of 23 rural and remote regions can access specialist care without leaving home. Telehealth also promotes continuing medical education and information-sharing for rural and remote health care providers.

In 2003, about five per cent of Manitobans surveyed in the 2003 Health Services Access Survey indicated that they had accessed some form of telehealth service within the last 12 months. An estimated 84 per cent said that they were very or somewhat satisfied with the way health care services were provided (Figure 28), and about 80 per cent rated the quality of care they received as excellent or good (Figure 29).

Community-based care

Community-based care includes home nursing care, personal care, home-based counseling or therapy, and visits to community walk-in clinics. It excludes visits to doctor offices. The 2003 Health Services Access Survey asked Manitobans about their level of satisfaction with community-based care they received in the past 12 months. An estimated 17 per cent of Manitobans (15 per cent of Canadians) reported that they had received some kind of community-based health care in the preceding 12 months.

Of those, an estimated 81 per cent indicated that they were very or somewhat satisfied with the way services were provided for their last visit (Figure 28) and about 76 per cent rated the quality of care received as excellent or good (Figure 29).

Physician care

Physician care includes receiving some kind of care from a physician, a family doctor or medical specialist (but excludes services received in a hospital). The 2003 Health Services Access Survey asked Manitobans how satisfied they were with the physician care they received in the past 12 months. An estimated 63 per cent of Manitobans (63 per cent of Canadians) reported that they had received some kind of care from a physician in the preceding 12 months. An estimated 91 per cent of them said that they were very or somewhat satisfied with the way health care services were provided at their latest physician visit (Figure 28), and about 92 per cent rated the quality of care received as excellent or good (Figure 29).

Hospital care

Although the main focus of this report has been healthy living and prevention, there will still always be the need for hospital or acute care services. The 2003 Health Services Access Survey asked Manitobans about their experience over the preceding 12 months in receiving some form of health care services at a hospital, as an inpatient, outpatient or as an emergency room patient. An estimated 27 per cent of Manitobans (27 per cent of Canadians) reported that they had received health care services at a hospital in the preceding 12 months. Within that group, an estimated 83 per cent indicated that they were very or somewhat satisfied with the way the health care services were provided for their most recent visit (Figure 28) and 82 per cent rated the quality of care received as excellent or good (Figure 29).

Conclusion

"Healthy living" is a contemporary way to describe the prevention of disease and injury, as well as the promotion of quality of life. Creating better conditions for healthy living and adopting healthy behaviors is a responsibility shared by governments, industry, communities and individuals.

It is hoped that Manitobans will use the information in this report in a variety of ways to become healthier and reduce health inequalities within our population. In the simplest analysis, these data can be used as indicators of prevention, disease rates and the quality of health care provided to Manitobans. Data, such as those in this report, are a useful reference for this ongoing work by indicating our current status and what more can be achieved. In most cases, the information presented should stimulate further discussion and research. The main goal of this report will be achieved if the indicators presented can be interpreted to show us where action is needed now, and in the future, to improve the overall health of Manitobans, while reducing disparities of health among Manitobans.

GLOSSARY

ACRONYMS

AMI	See Acute Myocardial Infarction
BMI	See Body Mass Index
CCHS	See Canadian Community Health Survey
COPD	See Chronic Obstructive Pulmonary Disease
HALE	See Health Adjusted Life Expectancy
HSAS	See Health Services Access Survey
NPHS	See National Population Health Survey
PAP test	Papanicolaou test – A study of the shed cells of the cervix or vagina for early detection of cancer cells.
PYLL	Potential Years of Life Lost. The number of years of life lost when a person dies prematurely (a premature death is defined as one occurring before 75 years of age).
STI	Sexually Transmitted Infection

TERMS

Acute myocardial infarction	A sudden loss of functioning heart tissue due to decreased blood flow to an area of the heart; also known as a heart attack.
Age-standardized	A statistical calculation that adjusts for differences in the age distributions between two groups, permitting comparisons across different groups, or over time.
Ambulatory care sensitive conditions	Health conditions where hospitalization could likely be avoided through early disease management in a primary care setting such as a doctor's office or community clinic. They include conditions such as diabetes, depression, hypertension and asthma.
Body Mass Index	An index that relates a person's body weight to their height. The body mass index (BMI) is a person's weight in kilograms divided by their height in meters squared. A BMI between 18.5 and 24.9 is considered ideal.
Canadian Community Health Survey	A cross-sectional health survey administered every two years by Statistics Canada to a representative sample of Canadians aged 12 years and older.
Chlamydia	A sexually transmitted infection (STI) caused by bacteria called *Chlamydia trachomatis*.

Chronic disease	Diseases that are expected to require a long period of supervision, observation, or care. They include conditions such as cardiovascular disease, diabetes, cancer, chronic obstructive pulmonary disease, asthma, and mental illness.
Chronic obstructive pulmonary disease	A progressive disease that is characterized by difficulty, breathing, wheezing and a chronic cough.
Community-based care	Medical or supportive care that includes home nursing care, personal care, home-based counseling or therapy and visits to community walk-in clinics, but excludes visits to doctor's offices.
Elective	A treatment or procedure that is advantageous to the patient, but not urgent, and therefore planned in the future subject to the choice or decision of the patient or physician.
Frequency	The number of occurrences of a particular event over a certain period of time.
Health adjusted life expectancy	A measure of overall population health. Health adjusted life expectancy (HALE) combines measures of both age- and sex-specific health status, and age- and sex-specific mortality into a single statistic. HALE represents the number of expected years of life equivalent to years lived in full health, based on the average experience in a population. In this sense, it is not only a measure of quantity of life, but also a measure of quality of life. Full health, as defined for health adjusted life expectancy, is measured using the Health Utilities Index (HUI). The HUI describes a person's overall functional health based on eight attributes: vision, hearing, speech, mobility, dexterity, cognition, emotion, and pain and discomfort. The HUI score is calculated based on the number of attributes for which a person has a problem, as well as the level of severity. For example, vision ranges from perfect vision to blindness, while pain ranges from no pain to completely disabling pain. Based on the scores for each of the eight health attributes, a person receives a score between zero and one with zero representing death and one representing complete/full health.
Health Services Access Survey	A health survey supplement to the Canadian Community Health Survey (CCHS) administered by Statistics Canada to a representative sample of Canadians aged 15 years and older.
Health status	The state of health of an individual, group or population, measured against an accepted standard.
Immediate care	Medical care for a minor health problem that is provided by a family or general physician, nurse or other health care provider. This does not include care provided by medical specialists.

Incidence	The number of new cases of a condition occurring in a population over a specified period of time.
Income tercile	The division of the population, ranked by income, into three equal groups.
Infant mortality	The number of infants (weighing at least 500 grams at birth) that die within the first year of life.
Life expectancy	The average number of years that a group of people of the same age and gender are expected to live assuming constant mortality rates.
Low birth weight	The proportion of live births with a birth weight between 500 and 2,500 grams.
Mammography	The use of x-rays to examine the breasts, commonly for cancer.
Median	A statistic that measures the mid-point of a series of ranked numbers. An equal number of items will fall above and below this point.
Modifiable risk factors	Risk factors that can be altered or eliminated.
Morbidity	The state of being sick, or of having a disease.
Mortality	The death rate. The ratio of the total number of deaths to the total population.
National Population Health Survey	A 20-year longitudinal survey of a representative sample of Canadians that is administered by Statistics Canada and conducted every two years.
Prevalence	The number of persons in the population who are living with a particular condition over a specified period of time.
Primary health care	The first level of contact with the health system where services are mobilized to promote health, prevent illnesses, care for common illnesses, and manage ongoing health problems.
Rate	A measure of the frequency with which an event occurs. It is calculated by dividing the number of events (ex: deaths from lung cancer) by the population at risk of experiencing the event (ex: the total population) over a particular unit of time.

Routine care	Health care provided by a general practitioner. This would include annual check-ups, blood tests or routine care for an ongoing illness.
Screening	Examination of people with no symptoms, to detect unsuspected disease.
Self-reported health status	A person's perception of how healthy they think they are. Generally measured using a rating scale of excellent, very good, good, fair or poor.
Significance testing	The application of statistical techniques to determine if the differences in values reported were statistically different or if there was essentially no difference.
Telehealth	(1) The use of satellite video conference technology to provide patients and care givers with the ability to access specialist care, to promote continuing medical education and to share information with rural and remote health care providers. (2) Phone-in health lines that provide health information to the public.

DATA CLARIFICATION

Prevalence of Diabetes: Limitations

1 Three types of diabetes are included in the databases: type 1, type 2 and gestational diabetes.

2 A baseline error rate of 20 to 25 per cent exists in the published (1999-2000) data.

3 This level of error is accepted by Health Canada and by those national experts identified by Health Canada.

4 Since 1997-98, these data have been accumulating false positives. For the data published here, this may not have a significant impact. Health Canada plans to work to reduce these errors so that by the time they publish the 2001-02 data, this accumulation will not become significant.

5 This baseline error rate is likely to vary by age and sex groups.

Incidence of Lung Cancer: Limitations

The Auditor General of Canada noted:

"A Statistics Canada study on the capture of Manitoba cancer cases shows that the cancer data are fairly complete, and therefore I can form an opinion on Manitoba data only. However, because not all jurisdictions have had such a study completed on the capture of cancer data, I cannot form an opinion on any comparisons that are made with the national incidence rates of cancer."

Appendix: Complete List of Comparable health Indicators

Based on the requirements set out in the 2000 Communiqué and the 2003 Health Accord, and with input from a range of stakeholders and experts, consultation with other FPT groups and the general public, 70 indicators (81 sub-indicators) were developed. These indicators are listed below grouped by the following categories:

- Healthy Canadians
- Primary Health Care
- Home Care
- Other Programs and Services
- Catastrophic Drug Coverage & Pharmaceutical Management
- Diagnostic and Medical Equipment
- Health Human Resources

Where available, data for the indicators listed in this appendix are reported for all provinces, territories and the federal governmet, in print and/or on the worldwide web. A document with detailed technical specifications on which the indicators were based is available at **www.cihi.ca/comparable-indicators** (or **www.icis.ca/indicateurs-comparables**). Manitoba data on the entire set of indicators from the 2004 reporting cycle is available on the Manitoba Health website **www.gov.mb.ca/health/index.html** (or **www.gov.mb.ca/health/index.fr.html**). This same information, along with comparable information for all the provinces, territories and the federal government, is available at **www.cihi.ca/comparable-indicators** (or **www.icis.ca/indicateurs-comparables**). Additional copies of Manitoba's written report can be obtained from:

Health Information Management
4th Floor, 300 Carlton St
Winnipeg, MB R3B 3M9
Phone: (204) 786-7139
FAX: (204) 944-1911

Healthy Canadians

- Life expectancy
- Life expectancy by income
- Health adjusted life expectancy (HALE)
- Health adjusted life expectancy (HALE) by income
- Infant mortality
- Low birth weight
- Mortality rate for lung cancer
- Mortality rate for prostate cancer
- Mortality rate for breast cancer
- Mortality rate for colorectal cancer
- Mortality rate for acute myocardial infarction (AMI)
- Mortality rate for stroke
- Five-year relative survival rate for lung cancer
- Five-year relative survival rate for prostate cancer
- Five-year relative survival rate for breast cancer
- Five-year relative survival rate for colorectal cancer
- Incidence rate for lung cancer
- Incidence rate for prostate cancer
- Incidence rate for breast cancer
- Incidence rate for colorectal cancer
- Potential years of life lost due to suicide
- Potential years of life lost due to unintentional injury
- Incidence rate for invasive meningococcal disease
- Incidence rate for measles
- Incidence rate for haemophilus influenza b (invasive) (Hib) disease
- Incidence rate for tuberculosis
- Incidence rate for Verotoxogenic E. Coli
- Incidence rate for Chlamydia
- Rate of newly reported HIV cases
- Prevalence of diabetes
- Exposure to second-hand tobacco smoke rate
- Self-reported health
- Teenage smoking rates: proportion current teenage smokers
- Teenage smoking rates: proportion daily smokers
- Physical activity
- Body mass index
- Immunization for influenza, aged 65 plus ("Flu Shot")
- Prevalence of depression

Primary Health Care

- Difficulty obtaining routine or on-going health services
- Difficulty obtaining health information or advice
- Difficulty obtaining immediate care
- Proportion of population that reports having a regular family doctor
- Patient satisfaction with overall health care services
- Patient perceived quality of overall health care services
- Patient satisfaction with community-based care
- Patient perceived quality of community-based care
- Patient satisfaction with telephone health line or telehealth service
- Patient perceived quality of telephone health line or telehealth service
- Proportion of population reporting contact with telephone health line or telehealth service
- Hospitalization rate for ambulatory care sensitive conditions
- Proportion of female population aged 18 to 69 with at least one PAP smear test in the past three years
- Proportion of women aged 50 to 69 obtaining mammography in the past two years

Home Care

- Home care clients per 100,000 population, all ages
- Home care clients per 100,000 population, aged 75 plus

Other Programs and Services

- Median wait time for cardiac by-pass surgery
- Distribution of wait times for cardiac bypass surgery
- Median wait time for hip replacement surgery
- Distribution of wait times for hip replacement surgery
- Median wait time for knee replacement surgery
- Distribution of wait times for knee replacement surgery
- Median wait time for surgery
- Distribution of wait times for surgery
- Median wait time for specialist physician visits
- Distribution of wait times for specialist physician visits
- Re-admission rate for acute myocardial infarction (AMI)
- Re-admission rate for pneumonia
- 30-day in hospital acute myocardial infarction (AMI) mortality rate
- 30-day in hospital stroke mortality rate
- 365-day survival rate for acute myocardial infarction (AMI)
- 180-day survival rate for stroke
- Patient satisfaction with hospital care
- Patient perceived quality of hospital care

Catastrophic Drug Coverage & Pharmaceutical Management

- Prescription drug spending as a percentage of income

Diagnostic and Medical Equipment

- Median wait time for radiation therapy for prostate cancer
- Distribution of wait times for radiation therapy for prostate cancer
- Median wait time for radiation therapy for breast cancer
- Distribution of wait times for radiation therapy for breast cancer
- Self-reported median wait times for diagnostic services
- Distribution of wait times for diagnostic services

Health Human Resources

- Patient satisfaction with physician care
- Patient perceived quality of physician care

NOTES

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MG-8278-11/04

Manitoba Health
Complete List of Comparable Health Indicators – Manitoba & Canada
November 30, 2004

Indicator Description (year of data in parentheses)	Indicator Number	Manitoba	Canada	Significance of Difference		Included in Published Report[2]
				Between Canada & MB	Between Genders	
Primary Health Care						
% of population having difficulty obtaining routine or on-going health services (2003)	1-PC	19%	16%	Not Significant	Not Applicable	Yes
% of population having difficulty obtaining health information or advice (2003)	2-PC	18%	16%	Not Significant	Not Applicable	Yes
% of population having difficulty obtaining immediate care (2003)	3-PC	25%	24%	Not Significant	Not Applicable	Yes
% of population that reports having a regular family doctor (2003)	4-PC	86%	85%	Not Significant	Not Applicable	Yes
Patient satisfaction with overall health care services - Very or Somewhat (2003)	5-PC	83%	85%	Not Significant	Not Significant	Yes
Patient perceived quality of overall health care services - Excellent or Good (2003)	6-PC	85%	86%	Not Significant	Not Significant	Yes
Patient satisfaction with community-based care - Very or Somewhat (2003)	7-PC	81%	83%	Not Significant	Not Significant	Yes
Patient perceived quality of community-based care - Excellent or Good (2003)	8-PC	76%	80%	Not Significant	Not Significant	Yes
Patient satisfaction with telephone health line or tele-health services - Very or Somewhat (2003)	9-PC	84%	84%	Not Significant	Not Significant	Yes
Patient perceived quality of a telephone health line or tele-health services - Excellent or Good (2003)	10-PC	80%	81%	Not Significant	Not Significant	Yes
% of the population reporting contact with a telephone health line or tele-health services (2003)	11-PC	6%	11%	Significant	A significantly lower proportion of Manitoba males have had contact compared to Manitoba females	Yes
Hospitalization rate per 100,000 for ambulatory care sensitive conditions (2001/2002)	12-PC	440	346	Not Applicable	Not Applicable	Yes
% of female population aged 18-69 with at least one PAP smear test in the past three years (2003)	13-PC	78%	75%	Significant	A significantly higher proportion of Manitoba females aged 18-69 received a PAP test in the past three years compared to Canadian females	Yes
% of women aged 50-69 with at least one mammogram for routine screening or other reasons within the last two years (2003)	14-PC	72%	71%	Not Applicable	Not Applicable	Yes
Home Care						
Number of home Care Clients per 100,000 population all ages (2002/2003)	15-HC	2,920	Not Available	Not Applicable	Not Applicable	No
Number of home Care Clients per 100,000 population ages 75 plus (2002/2003)	16-HC	26,679	Not Available	Not Applicable	Not Applicable	No
Other Programs and Services						
Median wait time for cardiac bypass surgery (Days) (2002/2003)	17a-OI	11	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting less than 15 days for cardiac bypass surgery (2002/2003)	17b-OI	55.5%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 15 to 42 days for cardiac bypass surgery (2002/2003)	17b-OI	16.8%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 43 to 180 days for cardiac bypass surgery (2002/2003)	17b-OI	21.3%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting more than 180 days for cardiac bypass surgery (2002/2003)	17b-OI	6.3%	Not Available	Not Applicable	Not Applicable	No
Median wait time for hip replacement surgery (weeks) (2002/2003)	18a-OI	19	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting less than 3 months for hip replacement surgery (2002/2003)	18b-OI	25.5%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 3 to 6 months for hip replacement surgery (2002/2003)	18b-OI	43.4%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 7 to 12 months for hip replacement surgery (2002/2003)	18b-OI	21.6%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 13 to 18 months for hip replacement surgery (2002/2003)	18b-OI	8.4%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting more than 18 months for hip replacement surgery (2002/2003)	18b-OI	1.1%	Not Available	Not Applicable	Not Applicable	No
Median wait time for knee replacement surgery (weeks) (2002/2003)	19a-OI	22	Not Available	Not Applicable	Not Applicable	No

1 Data should be used with caution due to small sample sizes

2 The data for indicators included in the "Manitoba's Comparable Health Indicator Report" have been audited. The remaining indicators have not been audited.

Manitoba Health
Complete List of Comparable Health Indicators – Manitoba & Canada
November 30, 2004

Indicator Description (year of data in parentheses)	Indicator Number	Manitoba	Canada	Significance of Difference		Included in Published Report[2]
				Between Canada & MB	*Between Genders*	
% patients who had surgery waiting less than 3 months for knee replacement surgery (2002/2003)	19b-OI	19.8%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 3 to 6 months for knee replacement surgery (2002/2003)	19b-OI	46.3%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 7 to 12 months for knee replacement surgery (2002/2003)	19b-OI	23.8%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting 13 to 18 months for knee replacement surgery (2002/2003)	19b-OI	8.2%	Not Available	Not Applicable	Not Applicable	No
% patients who had surgery waiting more than 18 months for knee replacement surgery (2002/2003)	19b-OI	1.9%	Not Available	Not Applicable	Not Applicable	No
Median wait time for non emergency surgery (weeks) (2003)	20a-OI	4.3	4.3	Not Significant	Not Applicable	No
% patients who had surgery waiting less than 1 month for non emergency surgery (2003)	20b-OI	41%	41%	Not Significant	Not Applicable	No
% patients who had surgery waiting 1 to 3 months for non emergency surgery (2003)	20b-OI	45%	41%	Not Significant	Not Applicable	No
% patients who had surgery waiting more than 3 months for non emergency surgery (2003)	20b-OI	14%[1]	17%	Not Significant	Not Applicable	No
Median wait time for specialist physician visits (weeks) (2003)	21a-OI	4.3	4.0	Not Significant	Not Applicable	No
% patients who waited less than 1 month for specialist physician visits (2003)	21b-OI	41%	50%	Not Significant	Not Applicable	No
% patients who waited 1 to 3 months for specialist physician visits (2003)	21b-OI	50%	40%	Not Significant	Not Applicable	No
% patients who waited more than 3 months for specialist physician visits (2003)	21b-OI	9%[1]	10%	Not Significant	Not Applicable	No
Re-admission rate for acute myocardial infarction (AMI) (00/01-02/03)	22-OI	Not Available	4.5%	Not Applicable	Not Applicable	No
Re-admission rate for pneumonia (00/01-02/03)	23-OI	Not Available	3.2%	Not Applicable	Not Applicable	No
30-day in hospital acute myocardial infarction (AMI) mortality rate (2001/2002)	24-OI	11.5%	11.8%	Not Applicable	Not Applicable	No
30-day in hospital stroke mortality rate (2001/2002)	25-OI	20.3%	18.7%	Not Applicable	Not Applicable	No
365-day net survival rate for acute myocardial infarction (AMI)	26-OI	Not Available	Not Available	Not Applicable	Not Applicable	No
180-day net survival rate for stroke	27-OI	Not Available	Not Available	Not Applicable	Not Applicable	No
Patient satisfaction with hospital care – Very or Somewhat satisfied (2003)	28-OI	83%	81%	Not Significant	Not Significant	Yes
Patient perceived quality of hospital care – Excellent or Good (2003)	29-OI	82%	83%	Not Significant	Not Significant	Yes
Catastrophic Drug Coverage and Pharmaceutical Management						
Prescription drug spending over 0% after tax income (2002)	30-DR	69%	65%	Significant	Not Applicable	Yes
Prescription drug spending over 1% after tax income (2002)	30-DR	29%	19%	Significant	Not Applicable	Yes
Prescription drug spending over 2% after tax income (2002)	30-DR	17%	11%	Significant	Not Applicable	Yes
Prescription drug spending over 3% after tax income (2002)	30-DR	10%	7%	Significant	Not Applicable	Yes
Prescription drug spending over 4% after tax income (2002)	30-DR	7%	5%	Significant	Not Applicable	Yes
Prescription drug spending over 5% after tax income (2002)	30-DR	4%	3%	Not Significant	Not Applicable	Yes
Diagnostic and Medical Equipment						
Median wait times for radiation therapy for prostate cancer (weeks) (2002/2003)	31a-DM	7.3	Not Available	Not Applicable	Not Applicable	No
% patients who waited up to 2 weeks for radiation therapy for prostate cancer (2002/2003)	31b-DM	9%	Not Available	Not Applicable	Not Applicable	No
% patients who waited 2 to 3 weeks for radiation therapy for prostate cancer (2002/2003)	31b-DM	12%	Not Available	Not Applicable	Not Applicable	No
% patients who waited 4 to 5 weeks for radiation therapy for prostate cancer (2002/2003)	31b-DM	40%	Not Available	Not Applicable	Not Applicable	No
% patients who waited 6 weeks or more for radiation therapy for prostate cancer (2002/2003)	31b-DM	39%	Not Available	Not Applicable	Not Applicable	No
Median wait time for radiation therapy for breast cancer (weeks) (2002/2003)	32a-DM	5.1	Not Available	Not Applicable	Not Applicable	No
% patients who waited up to 2 weeks for radiation therapy for breast cancer (2002/2003)	32b-DM	12%	Not Available	Not Applicable	Not Applicable	No
% patients who waited 2 to 3 weeks for radiation therapy for breast cancer (2002/2003)	32b-DM	26%	Not Available	Not Applicable	Not Applicable	No

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Manitoba Health
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Indicator Description (year of data in parentheses)	Indicator Number	Manitoba	Canada	Significance of Difference		Included in Published Report[2]
				Between Canada & MB	Between Genders	
% patients who waited 4 to 5 weeks for radiation therapy for breast cancer (2002/2003)	32b-DM	37%	Not Available	Not Applicable	Not Applicable	No
% patients who waited 6 weeks or more for radiation therapy for breast cancer (2002/2003)	32b-DM	26%	Not Available	Not Applicable	Not Applicable	No
Median wait time for diagnostic tests (weeks) (2003)	33a-DM	4.0[1]	2.0[1]	Not Significant	Not Applicable	Yes
% patients who waited less than 1 month for diagnostic services (2003)	33b-DM	48%	58%	Not Significant	Not Applicable	Yes
% patients who waited 1 to 3 months for diagnostic services (2003)	33b-DM	40%	29%	Not Significant	Not Applicable	Yes
% patients who waited more than 3 months for diagnostic services (2003)	33b-DM	13%[1]	13%	Not Significant	Not Applicable	Yes
Health Human Resources						
Patient satisfaction with physician care - Very or Somewhat (2003)	34-HR	91%	91%	Not Significant	Not Significant	Yes
Patient perceived quality of physician care - Excellent or Good (2003)	35-HR	92%	91%	Not Significant	Not Significant	Yes
Healthy Canadians						
Life expectancy for overall population at birth (years) (2001)	36a-HLT	78.6	79.6	Not Applicable	Not Applicable	Yes
Life expectancy for overall population at age 65 (years) (2001)	36a-HLT	18.8	19.0	Not Applicable	Not Applicable	No
Life expectancy by income at birth – males (years) (2001)	36b-HLT	75.5	76.9	Not Applicable	Not Applicable	No
Lowest income level	36b-HLT	72.2	75.2	Not Applicable	Not Applicable	Yes
Middle income level	36b-HLT	76.5	77.2	Not Applicable	Not Applicable	Yes
Highest income level	36b-HLT	77.7	78.4	Not Applicable	Not Applicable	Yes
Life expectancy by income at birth – females (years) (2001)	36b-HLT	81.2	82.0	Not Applicable	Not Applicable	No
Lowest income level	36b-HLT	79.7	81.4	Not Applicable	Not Applicable	Yes
Middle income level	36b-HLT	82.3	82.1	Not Applicable	Not Applicable	Yes
Highest income level	36b-HLT	81.3	82.5	Not Applicable	Not Applicable	Yes
Life expectancy by income at age 65 – males (years) (2001)	36b-HLT	16.6	17.0	Not Applicable	Not Applicable	No
Lowest income level	36b-HLT	15.7	16.4	Not Applicable	Not Applicable	No
Middle income level	36b-HLT	16.7	17.1	Not Applicable	Not Applicable	No
Highest income level	36b-HLT	17.3	17.5	Not Applicable	Not Applicable	No
Life expectancy by income at age 65 – females (years) (2001)	36b-HLT	20.4	20.5	Not Applicable	Not Applicable	No
Lowest income level	36b-HLT	20.4	20.6	Not Applicable	Not Applicable	No
Middle income level	36b-HLT	20.9	20.5	Not Applicable	Not Applicable	No
Highest income level	36b-HLT	19.6	20.4	Not Applicable	Not Applicable	No
Health adjusted life expectancy – males (years) (2001)						
At Birth	37a-HLT	66.7	68.3	Not Applicable	Not Applicable	Yes
Age 65	37a-HLT	12.2	12.7	Not Applicable	Not Applicable	No
Health adjusted life expectancy – females (years) (2001)						
At Birth	37a-HLT	70.4	70.8	Not Applicable	Not Applicable	Yes
Age 65	37a-HLT	14.3	14.4	Not Applicable	Not Applicable	No
Health adjusted life expectancy by income at birth – males (years) (2001)	37b-HLT	66.7	68.3	Not Applicable	Not Applicable	No
Lowest income level	37b-HLT	62.9	65.8	Not Applicable	Not Applicable	Yes
Middle income level	37b-HLT	67.7	68.6	Not Applicable	Not Applicable	Yes
Highest income level	37b-HLT	69.1	70.5	Not Applicable	Not Applicable	Yes
Health adjusted life expectancy by income at birth – females (years)	37b-HLT	70.4	70.8	Not Applicable	Not Applicable	No
Lowest income level	37b-HLT	67.7	69.1	Not Applicable	Not Applicable	Yes
Middle income level	37b-HLT	71.7	70.8	Not Applicable	Not Applicable	Yes
Highest income level	37b-HLT	71.2	72.3	Not Applicable	Not Applicable	Yes
Health adjusted life expectancy by income at age 65 – males (years) (2001)	37b-HLT	12.2	12.7	Not Applicable	Not Applicable	No
Lowest income level	37b-HLT	11.3	12.0	Not Applicable	Not Applicable	No
Middle income level	37b-HLT	12.7	12.9	Not Applicable	Not Applicable	No
Highest income level	37b-HLT	12.4	13.3	Not Applicable	Not Applicable	No
Health adjusted life expectancy by income at age 65 – females (years) (2001)	37b-HLT	14.3	14.4	Not Applicable	Not Applicable	No
Lowest income level	37b-HLT	14.0	14.2	Not Applicable	Not Applicable	No
Middle income level	37b-HLT	15.0	14.3	Not Applicable	Not Applicable	No
Highest income level	37b-HLT	13.8	14.7	Not Applicable	Not Applicable	No
Infant mortality rate per 1,000 live births (500 grams or more) (2001)	38-HLT	6.6	4.4	Not Applicable	Not Applicable	Yes
Proportion of low birth weight (500 grams or more, but less than 2,500 grams) (2001)	39-HLT	5.4	5.5	Not Applicable	Not Applicable	Yes
Mortality rate per 100,000 population for lung cancer	40-HLT	44.6	47.3	Not Applicable	Not Applicable	Yes

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(2001)						
Mortality rate per 100,000 population for prostate cancer (2001)	41-HLT	28.6	26.9	Not Applicable	Not Applicable	No
Mortality rate per 100,000 female population for breast cancer (2001)	42-HLT	23.2	25.0	Not Applicable	Not Applicable	Yes
Mortality rate per 100,000 population for colorectal cancer (2001)	43-HLT	18.2	18.4	Not Applicable	Not Applicable	Yes
Mortality rate per 100,000 population for acute myocardial infarction (AMI) (2001)	44-HLT	47.6	52.1	Not Applicable	Not Applicable	Yes
Mortality rate per 100,000 population for stroke (2001)	45-HLT	36.5	34.2	Not Applicable	Not Applicable	Yes
Five-year relative survival rate for lung cancer (1999)	46-HLT	16%	14%	Not Significant	Not Significant	No
Five-year relative survival rate for prostate cancer (1999)	47-HLT	91%	88%	Not Significant	Not Significant	No
Five-year relative survival rate for breast cancer (1999)	48-HLT	81%	83%	Not Significant	Not Significant	No
Five-year relative survival rate for colorectal cancer (1999)	49-HLT	60%	57%	Not Significant	Not Significant	No
Incidence rate per 100,000 population for lung cancer (2000)	50-HLT	59.6	57.7	Not Significant	Not Significant	Yes
Incidence rate per 100,000 population for prostate cancer (2000)	51-HLT	122.9	123.8	Not Significant	Not Significant	No
Incidence rate per 100,000 female population for breast cancer (2000)	52-HLT	102.0	100.6	Not Significant	Not Significant	No
Incidence rate per 100,000 population for colorectal cancer (2000)	53-HLT	53.9	51.8	Not Significant	Not Significant	No
Potential years of life lost due to suicide per 100,000 population (2001)	54-HLT	375.4	398.9	Not Applicable	Not Applicable	Yes
Potential years of life lost due to unintentional injury per 100,000 population (2001)	55-HLT	937.9	584.6	Not Applicable	Not Applicable	Yes
Incidence rate per 100,000 for invasive meningococcal disease (2002)	56-HLT	2.51	1.31	Not Applicable	Not Applicable	No
Incidence rate per 100,000 population for measles (2002)	57-HLT	0.09	0.02	Not Applicable	Not Applicable	No
Incidence rate per 100,000 population for haemophilus influenza b(invasive)(Hib) disease (2002)	58-HLT	1.4	0.9	Not Applicable	Not Applicable	No
Incidence rate per 100,000 population for tuberculosis (2002)	59-HLT	8.5	5.2	Not Applicable	Not Applicable	No
Incidence rate per 100,000 population for Verotoxogenic E. Coli (2002)	60-HLT	6.4	3.9	Not Applicable	Not Applicable	No
Incidence rate per 100,000 population for Chlamydia (2002)	61-HLT	289.1	178.9	Not Applicable	Not Applicable	Yes
Rate per 100,000 population of newly reported HIV cases (2003)	62-HLT	9.6	7.9	Not Applicable	Not Applicable	No
% of population 20+ years with diabetes (1999/2000)	63-HLT	5.5%	4.8%	Not Applicable	Not Applicable	Yes
% of population 12+ years exposed to second hand tobacco smoke - at home (2003)	64-HLT	11%	11%	Not Significant	Not Significant	Yes
% of population 12+ years exposed to second hand tobacco smoke - in private vehicles (2003)	64-HLT	11%	10%	Not Significant	Not Significant	Yes
% of population 12+ years exposed to second hand tobacco smoke - in public places (2003)	64-HLT	20%	20%	Not Significant	Not Significant	Yes
% of population 12+ years who reported their health as Very Good or Excellent (2003)	65-HLT	62%	60%	Significant	A significantly higher proportion of Manitoba females reported their health as very good or excellent compared to Manitoba males and Canadian females	Yes
% of population 12+ years who reported their health as Good (2003)	65-HLT	28%	30%	Significant	Not Significant	Yes
% of population 12+ years who reported their health as Fair or Poor (2003)	65-HLT	10%	11%	Not Significant	Not Significant	Yes
% of population 12-19 years old who are current smokers (2003)	66a-HLT	14%	15%	Not Significant	Not Significant	Yes
% of current smokers 12-19 years old who are daily smokers (2003)	66b-HLT	9%	9%	Not Significant	Not Significant	Yes
% of population 12+ years who are physically active (2003)	67-HLT	28%	27%	Not Significant	A significantly higher proportion of Manitoba males are active compared to Manitoba females	Yes
% of population 12+ years who are moderately active (2003)	67-HLT	23%	24%	Not Significant	Not Significant	Yes

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% of population 12+ years who are inactive (2003)	67-HLT	47%	46%	Not Significant	A significantly higher proportion of Manitoba females are inactive compared to Manitoba males	Yes
% of population 18+ years with a body mass index – Underweight (2003)	68-HLT	2%	3%	Not Significant	A significantly lower proportion of Manitoba males are underweight compared to Manitoba females	Yes
% of population 18+ years with a body mass index – Normal (2003)	68-HLT	42%	48%	Not Significant	A significantly lower proportion of Manitoba males have a normal weight compared to Manitoba females	Yes
% of population 18+ years with a body mass index - Overweight (2003)	68-HLT	34%	32%	Not Significant	A significantly higher proportion of Manitoba males are overweight compared to Manitoba females	Yes
% of population 18+ years with a body mass index – Obese (2003)	68-HLT	18%	15%	Not Significant	A significantly higher proportion of Manitoba males are obese compared to Manitoba females	Yes
% of population 65 + years who received an immunization for influenza within the past year (2003)	69-HLT	56%	62%	Significant	A significantly lower proportion of Manitoba males were immunized compared to Canadian males	Yes
% of population 12+ years who are likely depressed (2001)	70-HLT	7%	7%	Not Significant	A significantly lower proportion of Manitoba males are likely depressed compared to Manitoba females	Yes

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